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Senate Hearing

Before the Committee on Appropriations

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MEDICARE CATASTROPHIC COVERAGE ACT AND LONG-TERM CARE

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

ONE HUNDREDTH FIRST CONGRESS

FIRST SESSION

SPECIAL HEARING

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CONTENTS

	Page
Statement of Joe Tilghman, Deputy Regional Administrator, Health Care Financing Administration, region VII, Kansas City	1
Opening remarks of Senator Harkin	1
Summary statement	5
Prepared statement of Joe L. Tilghman	13
Statement of Jack Seeber, president, Iowa Council of Senior Citizens	16
Prepared statement of Jack Seeber	19
Statement of Joe Rodecap, chairman, Committee to Correct Inequities in Social Security and Medicare	24
Prepared statement of Joseph Rodecap	26
Statement of Shirley Henderson, senior advocate, Heritage Agency on Aging	33
Prepared statement of Shirley Henderson	36
Statement of Lonnie Conger, president, Iowa Federation of Chapters of National Association of Retired Federal Employees	39
Prepared statement of Lonnie Conger	41
Statement of Robert A. Jackson, Sr., Medicare beneficiary	42
Prepared statement of Robert A. Jackson Sr	44
Statement of Jane Roberts, vice chair, State Legislative Committee, American Association of Retired Persons	47
Prepared statement of Jane Roberts	50
Statement of Ronald F. Pollack, executive director, Villers Foundation	54
Statement of Loretta Tarbox, director of nursing, Villa Center and member, Nurses Advisory Committee	57
Prepared statement of Loretta Tarbox	59
Catastrophic health care now in effect	60
Changing costs	61

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MEDICARE CATASTROPHIC COVERAGE ACT AND LONG-TERM CARE

WEDNESDAY, APRIL 17, 1989

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Des Moines, IA.

The subcommittee met at 8:30 a.m., at the Mercy Education Building, Des Moines, IA, Hon. Tom Harkin (chairman) presiding.

Present: Senator Harkin.

NONDEPARTMENTAL WITNESSES

STATEMENT OF JOE TILGHMAN, DEPUTY REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, REGION VII, KANSAS CITY

OPENING REMARKS OF SENATOR HARKIN

Senator HARKIN. Good morning. I want to welcome you all. The Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies will come to order. I am pleased to convene this hearing here in Des Moines to first examine the Medicare Catastrophic Coverage Act and then to look at the next health care challenge facing the Nation, and that is long-term care.

As chairman of this Appropriations subcommittee, second in budget only to the Defense Subcommittee, I wanted to have this hearing because of the amount of mail that not only I have gotten, but my subcommittee has received—not only from Iowa but from around the country—concerning the financing of catastrophic health care and also the related problem of long-term health care. And so I wanted to bring the subcommittee here to Des Moines to hear first hand about this program. Iowa is No. 2 in the Nation in terms of the number of elderly per population, those over 65. Iowa is No. 1 in the Nation in terms of the number of elderly over age 85 that we have with regard to our total population. So I couldn't think of a better place to have this hearing than here in my home State of Iowa.

First, we'll hear from the Health Care Financing Administration as to what the Catastrophic Coverage Act provides and how those benefits will be financed. We will next have two panels of Iowans who will focus on the impact of the new legislation on Medicare

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beneficiaries, with the final panel addressing the issue of long-term care.

I'd like to take the first few minutes to highlight some key points which I believe are relevant to the catastrophic care legislation this morning.

For years Congress and organizations advocating on behalf of the elderly recognized that actions had to be taken to protect the elderly from financial ruin when faced with large, unpredictable health care expenses.

Rapidly rising health care costs, no upper limits on out-of-pocket costs paid by Medicare beneficiaries, and a steadily increasing elderly population, together these spelled out a prescription for disaster for all too many of our Nation's seniors. Then in his 1986 State of the Union message, President Reagan indicated his support for the concept of catastrophic health insurance. Now, I think it's important to note that he said he supported the concept of catastrophic health insurance. We'll get back to this in a second. The package subsequently submitted by then Secretary of Health and Human Services, Dr. Bowen, however, was too limited. It provided no assistance with the high cost of prescription drugs, it did not expand the existing hospital and medical services covered by Medicare, it did nothing to protect the spouse of a hospitalized beneficiary from exhausting all of their financial resources to pay for that person's care.

As the catastrophic legislation moved through Congress, improvements were made in the benefit package, including the addition of significant protections against spousal impoverishment, increases in the number of covered days of home health care and skilled nursing facility care, phased-in coverage for catastrophic prescription drug expenses, as well as unlimited hospital care, after paying one deductible a year. These improvements were all opposed by the administration, which contended they would be entirely too costly.

The administration also set forth a requirement that would have to be met before the President would sign the bill: The package would have to be self-financing, which means that all of the benefits would have to be paid for entirely by those who would receive it, in other words, the elderly. This, coupled with the climate of fiscal constraint under which we were operating placed extraordinary pressures on the limits of any catastrophic legislation. On more than one occasion, President Reagan told us that anything other than a self-financing mechanism would result in a veto of catastrophic health care legislation.

As you know, and as we were all aware in the Congress, this self-financing requirement represents a significant departure from the traditional way in which Medicare has been financed. Never before have the elderly been told they would have to foot the entire bill for expanded Medicare benefits. The premium associated with part B, the supplementary medical insurance portion of Medicare, has typically been set at 25 percent of the total cost, and the remaining 75 percent of the cost of those benefits were paid for by the Federal Government through general revenues. In other words, all of us paid in for 75 percent, the elderly paid for 25 percent.

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In 1989 the Federal contribution to part B costs will be about $30 billion. That's what we are paying for out of general revenues for supplementary medical insurance. Part A hospital benefits are financed through payroll taxes paid by employers and employees.

So let me make it clear that right now under Medicare, part A is paid for by employee and employer tax, which all of us who work pay into. Part B is paid for 25 percent by the elderly, 75 percent out of general revenues. That's the way we have always financed Medicare because we felt we all have to have some part in paying for it. President Reagan said he would veto any move by Congress to expand catastrophic Medicare health care in that manner, and that it would have to be paid for by the senior citizens entirely. So we were faced with a dilemma. There was a need recognized for the legislation, yet the President said he would veto it unless it was paid for by the elderly entirely. So how do you shape it in the most equitable manner possible?

Congress considered a number of alternatives. One proposal would have been to tax the value of Medicare benefits resulting in the entire financial burden placed solely on those elderly persons who pay income tax, meaning much higher premiums for those elderly who do pay income tax. That proposal was strongly opposed and quickly rejected. Another proposal was considered and rejected that would have allowed Medicare beneficiaries to opt out of the catastrophic coverage. That proposal was rejected for the same reason you don't want people to opt out of Social Security, it would simply drive up the premiums for the sicker elderly who also tend to be older and poorer. The President's proposal would have been to finance the benefits entirely through a flat premium on all Medicare beneficiaries, a proposal that would have placed a disproportionate share of the burden on the poorer elderly. Well, the less income you have, then the higher the proportion you pay, and the richer you are, the less it is. Fortunately, that was also rejected.

Instead Congress came up with what is now known as the two-tiered financing approach, which combines a flat premium of $4 a month in addition to the part B $27.90 monthly premium that you're now paying this year, plus a supplemental premium based on the income tax you owe. As many of you know all too well, the supplemental premium is essentially a surtax on your Federal income tax. What it means is that for every $150 income tax you owe, you'll also pay an additional $22.50 up to a maximum of $800 for tax year 1989.

It's important to understand that not all Medicare beneficiaries will pay the supplemental income-related premium. The estimates we have are that between 55 and 60 percent of all elderly Medicare beneficiaries will pay no supplemental premium for 1989. In other words, they will pay only the flat $4 a month additional part B premium in 1989. These are the individuals whose family incomes are so low they will owe less than $150 in Federal tax.

Why did Congress choose this means? Well, the two principles that guided me were this: No elderly person, rich, middle income, or poor, should have to go bankrupt when they face a catastrophic illness; second, I believe we have a responsibility to elderly persons at the lower end of the economic spectrum to see that their share of the financial burden is not disproportionately heavy. I have

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always opposed and will continue to oppose any efforts to balance the Federal budget on the backs of the elderly, the disabled, and the poor. Here we're talking about the most vulnerable members of our society, who we cannot and will not abandon in their time of need.

Was the financing solution we reached the best solution for the financing of these benefits? Maybe not. But with a threat by Ronald Reagan of a veto, there was nothing left we could do other than to find that kind of a mechanism. Since this legislation's enactment, I have heard from many of you who have serious reservations about the way it is financed. I have heard from many Iowans, indeed not wealthy ones, who have to pay some portion of the supplemental premium, and who had already purchased catastrophic benefits under private medigap plans. I understand about 70 percent of the elderly have such medigap plans. I've also heard from Federal retirees who have legitimate concerns about financing the new benefits, since they already have their plans and since all retirement that's paid to Federal retirees is fully taxable. I've also heard from those who are concerned that catastrophic legislation does not go far enough to address the health insurance needs of Americans. I couldn't agree more.

As the last panel will discuss today, there are 7 million Americans in need of long-term care. We have 37 million Americans who have no health insurance at all, including about 345,000 Iowans. And you can be sure any proposal to address these health care crises will be no less controversial or costly than the catastrophic care legislation we are discussing today. So I'm here today to listen to your reactions, and to hear any suggestions you may have for improvements to the catastrophic care. I'll also be looking to my older Iowans' task force for any suggestions they may have.

Finally, I wanted you to know that 1 month ago today I wrote to Senator Lloyd Bentsen, the Finance Committee chairman, to request a hearing to look at the impact of the Catastrophic Act on Medicare beneficiaries. Just last Wednesday the full Senate passed a resolution, which I was pleased to support, indicating its desire to have the Finance Committee hold hearings with particular attention to the financing mechanism that passed by an overwhelming vote of 97 to 2.

Now, Senator Bentsen has made a commitment that he will have hearings this year and listen to alternative proposals for financing catastrophic health care, so your message is being heard in Washington, and I will certainly be willing to listen to all constructive suggestions for changes. As I said, without Ronald Reagan in the White House, perhaps we have a chance at making some changes, if the will is there and if the support is there for such changes.

With that having been said, let us turn to our first witness, Mr. Joe Tilghman, Deputy Regional Administrator of the Health Care Financing Administration, who will give us an overview of the program.

Mr. Tilghman, I look forward to hearing your testimony. Your full statement will be included in the record, and I would appreciate you summarizing your opening statement so that we can have some time for questions.

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SUMMARY STATEMENT

Mr. TILGHMAN. Good morning. My name is Joe Tilghman. I'm Deputy Regional Administrator of the Health Care Financing Administration; as a lot of people know, there's a regional office in Kansas City. I'm pleased to be here today to discuss with you the principal elements of catastrophic health insurance under Medicare.

As most of you know by now, catastrophic health insurance represents the most comprehensive expansion of Medicare since the program's inception of 1965. The concept of catastrophic health insurance was forwarded by President Reagan and embraced by Congress over 2 years ago. Following more than a year of congressional debate, as the Senator pointed out, and months of dialog between Congress and the administration, the Medicare Catastrophic Coverage Act became law in July 1988. Its significance lies in the fact that it fills in many of the most pressing residual gaps in acute care coverage left by the original Medicare legislation.

While I think most of us are familiar with the details of catastrophic health insurance benefits, let me outline them very briefly: Under Medicare part A, the new benefits include several changes in the beneficiary's financial responsibility for inpatient hospital care. Effective January 1, 1989, beneficiaries are entitled to unlimited hospital care, following payments of only one hospital deductible per year; in addition, hospital coinsurances are completely eliminated.

Medicare coverage and skilled nursing facilities would also increase where we now pay for 150 days of care annually with significant reduced coinsurance amounts. To round out, hospice and home health care benefits have also been enhanced under part B. Beginning in January 1990, beneficiaries will be guaranteed that their out-of-pocket costs for physicians and other part B services will not exceed a reasonable amount. In 1990, for example, the cap for such covered part B services is set at $1,370. Medicare will pay 80 percent of covered part B services until a beneficiary's out-of-pocket expenses exceed that cap. At that point Medicare will begin paying 100 percent of part B services.

The catastrophic health insurance benefits will also provide in-home and respite care beginning January 9, 1991. This benefit will allow up to 80 hours care annually for certain disabled beneficiaries. In addition, Medicare beneficiaries will be entitled to preventive screening mammographies beginning January 1990.

An entirely new benefit, Medicare coverage and outpatient prescription drugs, have also been added under the catastrophic health insurance coverage. Beginning in 1990, Medicare will pay for immunosuppressive and certain home intravenous [IV] drugs. This benefit will be expanded to include all other prescription drugs approved for safety and effectiveness by the Food and Drug Administration. An annual deductible is required before Medicare payments begin. In 1991 the deductible is $600 and required coinsurance will be phasing in at 50 percent in 1991, 40 percent in 1992, and 20 percent in 1993.

There are also some protections, as the Senator mentioned, for low income beneficiaries: spousal protection against impoverish-

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ment when a spouse has to go into a nursing home, and also some protection for qualified Medicare beneficiaries.

In order to expedite this, what I'd like to do is to discuss the financing aspects of it and run through some of the mechanics——

Senator HARKIN. Yes. Thanks.

Mr. TILGHMAN [continuing]. As to how the financing mechanism works.

Senator HARKIN. Please.

Mr. TILGHMAN. The new benefits, including the drug coverage benefits, are to be financed by two premiums, as the Senator mentioned earlier. There's a flat premium that would be paid on a monthly basis, and a supplemental premium that would be tied to your Federal income tax liability. Total revenues from the flat premium are expected to pay about 37 percent of the total cost of catastrophic coverage once it's fully implemented, which is going to run about $10 billion a year, and I'll get into that later. The revenues from the supplemental premium, this is the one tied to your Federal income tax, are expected to pay the remaining 63 percent of the total cost of the coverage.

First, I'd like to talk about the flat premium. This is essentially an increase in your monthly part B premium. It applies to medical premiums that begin in January 1989. As most of you are probably aware by now, in 1988 the monthly part B premium was $24.80, and in 1989 this increased to $27.90. This is just your regular monthly part B premium. This increase was due to statutory requirement that premium revenues support 25 percent of the total part B program cost. In addition to this normal increase, there was also an increase in the part B premium of $4 a month that was due to the Catastrophic Coverage Act, that's a flat premium. Thus your total monthly part B premium is $31.90. This is an increase of $7.10 over which you paid in 1988. Now, of this increase, $3.10 you would have seen anyway just because of the increase in part B costs in the normal program, and then the $4 is due to the increase in catastrophic coverage. Now the law also provides for some increases in this flat premium over the next 3 to 4 years. In 1990 it will go up to $4.90 a month and increasing to $7.20 a month in 1993. The reason for the phased increase is that your benefits are also being phased in with part B benefits kicking in in 1990 and other coverage in 1991.

Now, I'd like to turn to the supplemental premium, which is the more controversial of the two financing mechanisms. This premium is new in 1989, and as the Senator mentioned, it's based on an individual's Federal income tax liability. It's an annual premium that's imposed on all individuals who are eligible for part A for 6 months or more in a calendar year and whose Federal income tax liability is $150 or more in that calendar year in 1989. It's limited to a maximum amount per individual of $800.

Now, if both spouses are eligible for Medicare part A during the year, that maximum premium is doubled for the family, so it becomes $1,600 in 1989. On the other hand, if only one spouse is eligible for Medicare part A during a year, then the tax liability for that Medicare eligible spouse for the purposes of determining the supplemental premium is one-half the family's total tax liability. For example, if you have a spouse that is eligible for the Medicare

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and the other one isn't, and the total tax liability is $5,000 in 1988, then you compute premiums on $2,500 for the one person who is eligible, with a maximum of $800. The law also provides for specific increases in the maximum supplemental premium through 1993, increasing from $800 in 1989 to $1,050 in 1993. The law also provides for specific changes in the premium tax rate in 1989, as the Senator mentioned. It's $22.50 per $150 of tax liability and—I don't recall the term, but I use the surtax rate—it would be 15 percent. Now that's going to go up to $42 per $150 of tax liability in 1993, a surtax, if you would, of 28 percent, which would be phased in over the next 4 years, increasing gradually each year.

To reemphasize, it's important to note that any Medicare-eligible individual with a tax liability of less than $150 pays no supplemental premium, as he indicated, is estimated that about 55 percent of you Medicare beneficiaries will not have to pay any supplemental premium because of this provision inserted by Congress. It's also estimated that only 5 percent of the Medicare beneficiaries will have to pay the maximum premium of $800. That might jump to as much as 10 percent once it's fully paid in in 1993. The actual income amounts vary, depending on how much tax deductions a person has and such, but it's been estimated that in 1988 to have to pay the full amount an individual would have to have an income of about $40,000 to $45,000, or a family would have to have an income of somewhere between $80,000 to $90,000, but that will vary depending on what you're able to claim as deductions on your income tax.

In summary, I'd like to recap a little bit. Just to summarize it, and put it into perspective as far as what this means to the individual, what they have to pay in 1988, what you as an individual pay, the premium was $297. We'll round that off to $300, roughly. Now, in 1989 in addition to what you would normally have to pay under your part B premium, everyone will have to pay at least an additional $48 a year, which is the flat premium, and it could range as high as $848 for those people who have to pay the additional premium. In other words, depending on where your income is, the additional cost to you, the beneficiary, for the catastrophic coverage is going to range from $48 up to $848 in the calendar year 1989.

Now, that's going to increase in the next 4 years where in 1993 it will cost you at least $122.40, which is just your flat premium multiplied times 12, up to about $1,200, slightly below $1,200. It would be the maximum any individual would have to pay once this is in place. So once again, when it's physically paid in, the maximum cost to any individual might be $1,200. That will probably be 10 percent of all Medicare beneficiaries. The minimum cost will be $122 a year, which will be more than one-half. So this gives you some idea of what we're talking about as far as the impact on individuals. That concludes my remarks, and I'd like to answer any questions.

Senator HARKIN. Thank you very much for being here this morning. I assume you came up from Kansas?

Mr. TILGHMAN. Yes, sir.

Senator HARKIN. I don't know if you saw this morning's Des Moines Register, but the editorial is called "Cheating the Elderly Poor," and the editorial is about the fact that the Catastrophic Act

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requires States to pay the monthly part B Medicare premium for poor beneficiaries, those that don't have a great deal of income, and I think it's to pay it for those elderly disabled with an income of under $5,083. The article says only nine States are complying with the law, Iowa being one of them. First of all, I assume it's not the first that you've heard of this problem, and, second, what is HCFA doing to make sure the States are meeting their obligation? Only nine States have done that.

Mr. TILGHMAN. I didn't see the editorial, but I'm familiar with the problem in general. First of all, this is one of the most important provisions in that it does provide a lot of financial protection for the elderly poor, and that the study that was done that was resulting in these editorials across the Nation was done by the Villers Foundation where they sent out questionnaires to individuals and asked them to complete it and send it back to them.

They used the results of this survey to compile this type of data that they disseminated through the news media. We were a little bit surprised when we started seeing the news articles appearing across the country because it didn't coincide with what the Health Care Financing Administration has been gathering over the past few months. It was supposed to be enacted in January 1, 1989, so it should have been in place and working. We went back and queried the States in our region, which includes Iowa, Kansas, Missouri, and Nebraska. We had copies of actual letters that they submitted to the Villers Foundation and asked them to give us some additional information to clarify this.

We do believe there was a lot of misinformation and inaccurate data used. This news article—in our region, for example, Iowa was the only State that was reported fully complied. We found out that Nebraska and Kansas were also and simply misreported by the Villers Foundation. Missouri was not in compliance, but there was a provision in the act itself that says if a State requires State legislation to implement any portion of the act, then they can get a delay. Missouri and a lot of the other States require some State legislation before they can implement these provisions. So in summary, I think a lot of the data used in the article is simply misleading, that we are on top of this. Iowa, for example, did implement on January 1, 1989. There are very few qualified Medicare beneficiaries that have been enrolled in the State of Iowa. The reason for that is Iowa has an excellent Medicaid program.

Senator HARKIN. We're hearing from the Villers Foundation later on this morning. Mr. Tilghman, the Medicare Catastrophic Coverage Act has imposed a considerable workload on everyone. Cay you tell us how the implementation is proceeding, and will there be any delays?

Mr. TILGHMAN. We're busy; there's a lot of work to be done in implementing the catastrophic plan. We don't anticipate any delays at this time. The only thing that really worries us a lot is the drug coverage. That's a major change over what we've ever done in the past, but we are excited about it. There are some provisions provided by the law itself that are very exciting. One of them is the point of sale requirements, where, when you go to the drug store, be it the local drug store or supermarket or whatever, there will be a computer or computer terminal hookup there where it

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will all be processed by the pharmacist. He would enter your name, Social Security number, and within a matter of seconds he'll get back information saying that you are, in fact, covered here, how much Medicare will pay for the drugs; here's how close you are in meeting your deductible for the year. And one of the exciting things about point of sale is that we will also be able to tell that pharmacist that, here are the other drugs that you are also currently being prescribed. And if there's going to be any bad interaction between—some people may have 10 different drugs that they're getting. There will be a computer analysis of the different drugs that you're receiving to see if there's going to be any bad interaction that the pharmacist should be aware of and call your attention to and change the prescription or whatever. In fact, we're very excited about the provisions that have been implemented.

Senator HARKIN. If you can't answer this, I can understand fully. I just wonder if you know through the administration or your supervisors in HHS what the position of the administration will be. As mentioned in my statement, the Senate passed a resolution by 97 to 2 to have some hearings; Senator Bentsen said he would have hearings this year. Do you know what the position of the Bush administration will be? Will they oppose any changes that would spread out the financing, or will they adhere to the former President's proposal that it be fully financed by the beneficiaries? Do you have any knowledge of that?

Mr. TILGHMAN. Yes; I do. If I could, I would like to expand a little bit on some of the rationale behind our position; also it might reflect on some of the thought that went into the original legislation as of last Friday. The answer is we are currently opposed to any changes in the financing mechanism that would result in new taxes. I don't see that change at any point in the future.

Senator HARKIN. When you say, result in new taxes, do you include FICA Social Security taxes?

Mr. TILGHMAN. Yes, sir.

Senator HARKIN. The ones that I pay on my income, for example?

Mr. TILGHMAN. Yes, sir; the FICA as well as the general revenue type taxes. The blunt term that I received last Friday was: "No new taxes," which I interpret that to mean on FICA taxes or Social Security taxes which you're paying in your Federal income taxes, or taxes on cigarettes, tobacco, alcohol, any form of new taxes. That is my understanding.

Now, I'll be one of the few people speaking in favor of current financing mechanisms today. With your permission, sir, I'd like to digress for a second and explain some of the rationale that was used in arriving at this position. I'll repeat a little bit, a couple of the background things that the Senator said early in talking about Medicare in general. In the past, and this is a dramatic departure from past money mechanisms, Medicare benefits have been funded up through three sources: Your FICA taxes, general revenues, and beneficiaries' premiums. Now, a portion of the financing taxes are FICA taxes that you pay, which are borne by all of the Nation's working population, are used to pay for all Medicare part A benefits which in 1988 came to a total of $53 billion in the country. Part B benefits, this is physicians' services, are funded 25 percent by

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your monthly premium and the rest comes out of the general revenue. Part B benefits were $37 billion in fiscal year 1988. Now, unlike previous financing mechanisms, there's a large change in the catastrophic. First off, as he pointed out, the revenue sources are limited entirely to those people who benefit from the expanded coverage, and, second, within that group of beneficiaries, those with higher incomes are expected to pay a higher share of the total cost. The rationale for this includes several things I want to touch on.

To go back to my dollar figures earlier, part B benefits were $37 billion last year; part A, $53 billion total paid last year in the country. Now, the Senator is more knowledgeable on this than I am, but my understanding is that that represents the fourth largest segment in the total Federal budget behind the Department of Defense, behind Social Security benefits, and behind debt on—the interest on the national debt. It's a huge huge part of the budget. Now, we're all aware of the current problems we have trying to balance the Federal budget. It would have been irresponsible of Congress to pass additional benefits for the Medicare population—they're going to cost an additional $10 billion a year once they are implemented—unless they also implemented revenues to pay for this. All they would be doing is adding to the national debt. In figuring out how to pay for this, keep in mind that your part B benefits amount to somewhere around $9 billion in income, which represents about 10 percent of the total Medicare payout in a year. The other 90 percent is paid by the working population, either through general revenues or through FICA actions.

Senator HARKIN. Please explain that to me again, I think I missed that one.

Mr. TILGHMAN. The part A benefits amounted to $53 billion last year. These are all paid for and funded out of your part of the FICA taxes. Part B benefits were $37 billion last year, 25 percent of that is paid by the part B monthly premium, which would be, roughly, $9 billion. The other 75 percent is paid by general revenues. The total part A and part B payouts last year were $90 billion 53 plus 37. Of that $90 billion, $9 billion, 25 percent of the part B cost, was paid by the monthly part B premium, or by you the Medicare beneficiaries. The other $81 billion, or 91 percent of the total cost, was paid by the working population, either through their general tax revenues or through the FICA.

So you, the Medicare population, paid roughly 10 percent of the total cost of the Medicare program. The other 90 percent is considered income transferred from the working population to the Medicare population. The thought was that, as the Senator alluded to earlier, if you look ahead in the years, in the next two decades or so, there's going to be a drastic change in the demographics of the American population, call it the grain of Americans, where right now 1 person in 7 is over age 65. That's going to drop by the year 2010 to 1 in 5, so you're going to have this huge increase in the Medicare population, while at the same time you've got the decrease in the working population.

So looking ahead at that, you can't continue to have this transfer of income from the working population to the elderly population because at some point it's going to break the back of the working

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population because of the shifting in people. So the thought was, let's shift some of the cost of their own benefits to the Medicare population themselves. Also this is supported a little bit by an analysis, which I don't have any figures in front of me, but the financial state of the elderly has improved considerably in the past 20 years since Medicare was implemented, where they're in a lot better position to help pay some of their costs than they were 20 years ago. And that's one aspect—we simply can't afford to go any further in the direction we're going and expand benefits. We need to reverse it and get some of the costs back on the Medicare beneficiaries themselves.

This was also supported by a concept that currently about 75 percent of all Medicare beneficiaries have some form of supplemental insurance, medigap, or whatever. Catastrophic protection was going to do two things: It was going to replace a lot of this supplemental insurance that people are currently paying for out of the their own pocket now, and it was also going to expand it, as well as provide uniform protection for 100 percent of the Medicare population. So the thought was also, since catastrophic insurance was going to replace for many people what they're currently paying for in the way of supplamental insurance policies, they should be expected to pick up the share of the cost of that new program. There are some other reasons, like progressive financing the Senator alluded to very well earlier, and that's a concept that has been borne out of this country over many years, that people that are better off financially should be expected to pay more than those who are less well off financially. That's part of why we went to the supplemental premium rather than going to the flat premium. That would have hurt a lot of the poor people.

Senator HARKIN. Thank you, Mr. Tilghman, for that explanation. One last question, and then I have to move on to our next panel. I understand that HCFA has prepared a 15-minute videotape explaining both the benefits and how the part B and supplemental premium will work. What is the status of that?

Mr. TILGHMAN. Let me point out that you're very well informed, Tom.

Senator HARKIN. It's my staff.

Mr. TILGHMAN. You've got a good staff, then. HCFA has prepared a total of 3,000 VHS videotapes, which I have a copy with me if you would like to see it. The videotape lasts 11 minutes, and about 2 weeks ago it was sent out to each Social Security district office, as well as each area agency on aging. We also sent a number of copies to AARP, the national association, and other beneficiary groups, and people can contact either the area agency on aging or their local Social Security office or your staff, I guess, after today. I can leave a copy with them to get a copy of that. We certainly encourage you, Tom, to look at it. It's an excellent tape and very, very informative, I believe.

Senator HARKIN. Do you have a copy with you?

Mr. TILGHMAN. Yes, sir; I've got a copy of it.

Senator HARKIN. I can leave it in my office, and we can loan it out.

Mr. TILGHMAN. That's fine.

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Senator HARKIN. Mr. Tilghman, thank you very much for being here from Kansas City and taking time from your job; I appreciate it. It was a very frank statement, and I just want you to know that I appreciate it very much.

Mr. TILGHMAN. Thank you, sir.

[The statement follows:]

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STATEMENT OF JOE L. TILGHMAN

Good morning, I am Joe Tilghman, Deputy Administrator of the Health Care Financing Administration Regional Office in Kansas City. I am pleased to be here today to discuss with you the principal elements of catastrophic health insurance under Medicare.

Background

Catastrophic health insurance represents the most comprehensive expansion of Medicare since the program's inception in 1965. The concept of catastrophic health insurance was forwarded by President Reagan and embraced by Congress over two years ago. Following more than a year of Congressional debate and months of dialogue between Congress and the Administration, the Medicare Catastrophic Coverage Act became law in July of 1988. Its significance lies in the fact that it fills in many of the most pressing residual gaps in acute care coverage left by the original Medicare legislation.

Catastrophic health insurance protects Medicare beneficiaries from the financial ruin an unusually long or particularly expensive illness may cause. The need to protect Medicare beneficiaries from such risk has become increasingly clear in recent years as the cost of health care has risen dramatically, and with it the burden of beneficiary cost-sharing. While I think most of us are familiar with the details of the catastrophic health insurance benefits, let me outline them briefly for the record.

Catastrophic Health Insurance Benefits

Hospital and SNF Care: Under Medicare part A, the new benefits include several changes in the beneficiary's financial responsibility for inpatient hospital care. Effective January 1, 1989, beneficiaries are entitled to unlimited hospital care,

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following payment of only one hospital deductible per year. In addition, hospital coinsurances are eliminated.

Medicare coverage of skilled nursing facility services is also expanded under the new benefit, with Medicare now paying for 150 days of care annually with significantly reduced coinsurance amounts. And, the requirement that a beneficiary must be hospitalized for three days prior to being admitted to a SNF has been dropped.

To round out part A coverage, both the hospice and home health care benefit have been enhanced. Medicare beneficiaries choosing the hospice option are entitled to an unlimited number of hospice days effective January 1, 1989 providing a physician certifies that hospice care is appropriate. Beneficiaries requiring home health care will find the number of covered days for daily nursing care expanded beginning in January of 1990.

Part B Cap: Under catastrophic health insurance, beneficiaries will be guaranteed that their out-of-pocket costs for physician and other part B services will not exceed a reasonable amount. In 1990, for example, the cap for such covered part B services is set at $1370. Medicare will pay 80 percent of covered part B services until a beneficiary's out-of-pocket expenses exceed $1370. At that point, Medicare will pay 100 percent of covered part B services. This benefit protects not only those beneficiaries experiencing a sudden illness, but will also likely help those whose chronic illness requires extensive physician services.

Other Part B Benefits: The catastrophic health insurance benefit will also provide in-home respite care beginning in January 1990. This benefit allows up to 80 hours of continuous care annually for certain disabled beneficiaries, thus providing needed respite

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for their ususal caretakers. In addition, Medicare beneficiaries will be entitled to preventive screening mammographies beginning in January, 1990.

Outpatient Prescription Drugs: An entirely new benefit, Medicare coverage of outpatient prescription drugs, has also been added under catastrophic health insurance. Beginning in 1990, Medicare will pay for immunosuppressive and certain home intravenous (IV) drugs. The benefit will be considerably expanded in 1991 to include all other outpatient prescription drugs approved for safety and effectiveness by the Food and Drug Administration (FDA). An annual deductible is generally required before Medicare payments begin. In FY 1991, for example, the deductible is $600. The required coinsurance will be phased in over the first several years of the program at 50 percent in 1991, 40 percent in 1992, and 20 percent in 1993.

Low-Income Protections: Finally, catastrophic health insurance provides special protections for low-income beneficiaries. Under the law, states are required to pay the Medicare premiums, deductibles, and coinsurances of all beneficiaries with incomes below the federal poverty level. In addition, the law allows a spouse who remains at home to keep a minimal level of income and assets when the other spouse is admitted to a nursing home. This important provision protects an individual who wants and is able to stay in the community to do so without becoming impoverished trying to pay the nursing home bills of a spouse.

Conclusion

Clearly, the new catastrophic health insurance benefits have generated much discussion among those concerned about Medicare benefits and their cost. We believe that such discussion is very positive, and we seek to encourage it. Late last year we mailed information explaining the new provisions to every Medicare

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beneficiary. We have also established a toll-free hotline to answer specific beneficiary questions. I am pleased to note that as of February, over 250,000 beneficiaries have taken advantage of this service. And, our carriers and fiscal intermediaries have developed beneficiary outreach programs to handle questions they may receive.

Let me conclude my statement by assuring you that HCFA is working hard to implement the new catastrophic health insurance benefits and to ensure that the transition to the new benefits, particularly the very complex outpatient prescription drug benefit, is smooth. Implementation of the new benefits has been, and continues, on schedule.

I would be pleased to answer any questions you may have.

STATEMENT OF JACK SEEBER, PRESIDENT, COUNCIL OF SENIOR CITIZENS

Senator HARKIN. We will now begin with our first panel and call to the witness table Mr. Jack Seeber, the president of the Iowa Council of Senior Citizens; Mr. Joe Rodecap, who is chairman of the Iowa Committee To Correct Inequities in Social Security and Medicare. Welcome. I'd appreciate you limiting your oral testimony to 5 minutes, so we'll have time for questions. Your full statements will be placed in the hearing record also. Mr. Rodecap, I also note that your committee is holding a meeting on May 5, to give Iowans information on catastrophic care legislation. I regret I can't be with you that day, as the Senate will be in session. I do thank you for your invitation, and I'll have someone from my staff at that hearing.

Mr. Jack Seeber, welcome. You are the president of the Iowa Council of Senior Citizens, I also might mention on my older Iowans' task force. I appreciate your being here, and if you could start, then we'll have Mr. Rodecap second.

Mr. SEEBER. Thank you, Senator. And first of all, I wanted to thank you for bringing this hearing to Iowa and giving us an opportunity to express our views. As president of the Iowa State council, I am also a member of the general board of the National Council of Senior Citizens who worked long and hard to try to get a better catastrophic bill. In some instances we were successful, in some cases, we were not. The Reagan administration did impose the self-financing regulation early, it came out as early as 1985 when the confirmation hearings were held for Secretary-nominee of the Department of Health and Human Services, Otis R. Bowen,

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also President Reagan's State of the Union address following in January. No question that Congress was under the threat of a veto of any method of financing. The national council, through our lobbyists in Washington, along with other senior groups, has been pressing for a long time for some type of catastrophic health care. We did impose from the very beginning the financing regulations that were imposed upon us, and we did fight for a better bill than we got.

In some instances, as I said, we were successful. We did defeat the fight for the prescription drug coverage; we felt that was entirely essential, and also for the low income provisions and the Medicare buyin that was discussed here this morning. Those we felt were also essential. We, at our general board meeting March 20 in Washington DC, held an all-day discussion on this bill and passed a resolution as to where we really ought to try to go from here.

First of all, Congress, in our opinion, has to rethink the entire financing mechanism. I think, and I would say this to the gentleman from the Bush administration, this would not be a new tax to share the financing of this burden around, take it off the backs of the elderly and share it with all of the population. The tax is there now, this would not impose any new taxes, it would just make sure that as acceptable principles of social insurance, all pay their fair share, not just a few. I think that the supplemental premium, in our opinion, should be done away with. I think that if the burden is shared, I think the revenues would make it possible. Certainly the elderly ought to pay part of it, no question about that, but we shouldn't have to pay it all.

However, the national council feels that there are enough good things in this bill that we oppose any delay in the implementation of benefits. We are not supporting repeal of the act at this time, but we are urging Congress to go in and repair the financing mechanism. We also want to be sure that the equal use of benefits is enforced strictly, and that would provide for employees or retirees who had catastrophic coverage under a plan provided by employers make sure that the employers pass those savings along to the employees. This is a very important point for many, many thousands of retirees.

All in all, we are disappointed that the bill did not address, in our opinion, the most pressing problem in America today: Long-term health care. That certainly is a problem that in 1989 or 1990 needs to be addressed. We are, however, happy with parts of the bill, and overall we feel that this financing can be straightened out to where everyone pays their share. It's not a great bill, but it does have enough benefits for some low income people, and I might say that, due to the efforts of the national council and the senior groups, that this year 20 percent of all Medicare beneficiaries will receive some benefits under the new law. The original administration proposal only provides that 3 percent would have received those benefits, so Congress did make some improvements. Certainly, as I mentioned, the prescription drug program was a big one, in our opinion. With that, Senator, I, again, thank you for coming here today.

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Senator HARKIN. Mr. Seeber, thank you very much for your testimony. Now, to make it clear: The National Council of Senior Citizens supports spreading out the financing—I'll ask you more questions about that—they oppose repeal and support implementing the present provisions of the catastrophic bill?

Mr. SEEBER. Yes; I think the benefits are so important to thousands of our senior citizens to delay implementation would be a mistake, in our opinion. But we also, with due speed, encourage the Congress to get busy on the financing mechanism. That's our problem.

Senator HARKIN. Thank you.

[The statement follows:]

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STATEMENT OF JACK SEEBER

Special Report to the General Board

NCSC and the Medicare Catastrophic Coverage Act

February 17, 1989

The following information describes the chain of events that led to passage of the Medicare Catastrophic Coverage Act and NCSC's role in the bill's development. It further describes NCSC's continued role in pushing for improvements in the new law.

The first part of this report is a chronology of the catastrophic bill, describing action taken by the Administration, Congress, and NCSC as the bill moved toward enactment.

This section shows that:

1) The self-financing requirement was imposed on the bill by the Reagan Administration, through the Office of Management and Budget, the Department of Health and Human Services, and the White House, as early as December 11, 1985, Secretary Bowen's confirmation hearing. This requirement was agreed to by House and Senate Democrats by April 1987;

2) NCSC pushed hard and often for other revenue sources;

3) Led the fight for prescription drug coverage proposing a $1.00 co-pay and a $200 deductible; and

4) Made clear to Congress our members' concern about the supplemental premium.

NCSC did not propose or advocate paying for the catastrophic benefits through a supplemental premium. Congress, however, was determined to pass the catastrophic health care legislation last year--with or without NCSC's support.

NCSC successfully lobbied <u>against</u> the House's original actuarial value scheme, which was even more regressive, and was able to push <u>for</u> improved benefits and coverage for the poor. As a result, 20 percent of all Medicare beneficiaries will directly benefit from the law this year, as opposed to three percent under the Administration's proposal and eight percent under the House proposal.

The second part of this report is a proposal for NCSC action on the catastrophic health care law in the future. It outlines substantive, realistic steps that NCSC will advocate to make the new law fairer and of greater value to all older Americans.

The Medicare Catastrophic Health Care Act
Legislative History and NCSC Role

Date	Event
-11-85	Senate confirmation hearings for Otis R. Bowen, Secretary-Nominee of the Department of Health and Human Services.

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Bowen proposes Medicare coverage of acute catastrophic expenses, financed by flat premium of $12/month for all beneficiaries. Self-financing principle is established.

-4-85 President's State of the Union Address

President Reagan announces that he was directing Bowen to report by the end of '86 on how the private sector and the Federal government can work together to cover catastrophic illness expenses.

-20-86 House and Senate Aging Committee joint hearing

Democratic Members of Congress say the Administration's proposal won't go far enough.

The Administration's Office of Management and Budget insists that coverage is limited to inpatient care only, and does not include long-term care. Reinforces self-financing.

1-12-86 Bowen report sent to the President

Proposal would help three percent of all Medicare beneficiaries, paid by $4.92 monthly premium on all Medicare beneficiaries. Covers hospital and physician care after $2,000 limit is reached.

-12-87 Reagan endorses Bowen plan

Administration's legislation is introduced in House by Rep. Michel and in Senate by Sen. Dole.

1-1-87 House Ways and Means Committee accepts budget neutrality requirement and elderly financing.

NCSC sent letter to Ways and Means Health Subcommittee urging a "fair and acceptable" financing method that would not put the costs exclusively on Medicare beneficiaries.

> "We propose: 1) that a prescription drug benefit be added to the catastrophic package; and
>
> 2) that Congress mandate a Medicaid buy-in for Medicare for out-of-pocket payments for the poor and the near poor, financed through revenues already set aside in the House budget resolution."

4-8-87 Senate Labor and Human Resources Committee hearing

NCSC testifies that catastrophic should not be financed by beneficiaries and proposes other revenue sources.

> "As always, it's a lot easier to talk about what benefits should be provided under a public health care program than it is to determine who should pay for the added benefits. But, in this case, I think the answer is a fairly simple one--the burden should be shared. It is vital to keep in mind, as we discuss health policy and its effect on the deficit, that, since 1980, domestic

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programs serving the poor and the elderly have sustained deep cuts, even as citizens have suffered increased costs while receiving less, the deficit has grown. As a result, many of our seniors are more vulnerable than at any time in recent history. The Medicare program's cuts already adopted will cost Medicare beneficiaries $14 billion over the next five years.

"Clearly, the elderly did not cause our current budget deficit. The Congressional Budget Office (CBO) recently found that, if the budget and tax policies that were in effect when the Reagan Administration took office had been continued, rather than changed, the Federal deficit in FY 1985 would have been $80 billion (about the same as in 1981) rather than the $212 billion level at which the deficit now stands. The changes in defense and tax policy, along with the increase in interest payments on the national debt, caused by these policies, added $167 billion to the Federal deficit in 1985, meanwhile, domestic cuts--including reductions in Social Security, Medicare and Medicaid--reduced the deficit by $38 billion. The net result was an increase in the deficit of about $130 billion.

"Let's keep in mind, then, that the elderly have done more than their fair share in being fiscally responsible and helping to reduce the Federal deficit. They have taken the cuts on the chin and in their wallets for seven years now and have asked for little in return.

"There are, however, very real savings that can and should be found through the providers of health care in our country and, in fairness, savings from these cuts should be targeted to pay, at least in part, for any Medicare coverage expansion."

NCSC proposes drug coverage with a $1.00 co-pay and a $200 deductible.

4-9-87 House Ways and Means Health Subcommittee approves Stark catastrophic bill.

Stark plan is financed by a combination of a flat premium and taxation of the actuarial value of the Medicare benefits. Labor unions, NCSC, others strenuously object to taxing actuarial value on the grounds that it would be the first step toward taxing fringe benefits.

5-5-87 Senator Bentsen, Senate Finance Committee Chair, introduces catastrophic bill.

5-19-87 Ways and Means Committee approves Stark bill, but without taxing actuarial value. First appearance of the supplemental premium as "progressive" alternative.

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In place of taxing the actuarial benefit of Medicare benefits, Ways and Means recommends a surtax paid by Medicare beneficiaries based on tax liability--estimated that 60 percent of elderly would pay no surtax.

The Ways and Means Committee bill would benefit 2.5 million beneficiaries, eight percent of all beneficiaries. Bill does not include coverage of prescription drugs.

5-29-87 Senate Finance Committee approves Bentsen bill.

Includes supplemental premium, does not include coverage of prescription drugs.

5-87 At NCSC's urging, Stark introduces bill to cover prescription drugs and holds hearing.

Bill includes a $500 deductible. NCSC testifies for coverage with a $200 deductible.

5-27-87 House Energy and Commerce Committee Health Subcommittee hearing on coverage of prescription drugs.

Administration testifies against coverage.

6-16-87 Ways and Means Health Subcommittee approves drug coverage.

Plan includes $800 deductible and 20 percent co-pay. NCSC goes on the record against an $800 deductible.

6-87 Energy and Commerce approves catastrophic bill with drug coverage.

Bill includes $500 deductible.

7-22-87 House passes catastrophic 302-127.

10-6-87 NCSC letter to Senate regarding catastrophic financing.

Letter argues for alternative financing since many NCSC members have expressed "genuine concern" about the costs of the catastrophic bill and since many of our members with retiree health benefits would have to pay more for largely duplicate benefits.

NCSC also pushed, in its letter, drug coverage with a low deductible.

10-28-87 Senate passes catastrophic with drug coverage 86-11.

2-22-88 NCSC sends Seniorgram to all clubs urging them to send letters in support of the Prescription Drug benefit, the Medicare Buy-In, and opposing the financing mechanism asking, instead, for more traditional and more progressive ways of paying for benefits.

5-88 House passes conference agreement.

6-9-88 Conference passes Senate.

7-1-88 President signs bill.

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:t II: Catastrophic Health Insurance: Where We Go From Here

As has been made clear in the above chronology, NCSC always recognized the inadequacy of both former President Reagan's Catastrophic Health Care initiative and the proposal enacted by Congress. In Congressional testimony, meetings with members of Congress and lobbying communications, we pointed out that the bill had limited benefits and that the financing burden placed upon the elderly would prove onerous.

Nevertheless, given the size of the federal deficit and the conservative leadership in the White House, we felt, and still feel, that the benefits in the legislation, particularly the prescription drug benefit and low-income protection, represent important improvements in the Medicare program. For this reason, NCSC opposes the repeal or delay in implementation of the Catastrophic Health Care benefits package.

However, NCSC continues to have serious reservations about the method of financing this initiative. We do not now, nor did we ever, support a program financed entirely by elderly citizens. Nor do we believe that traditional social insurance principles should have been violated to pay for the new benefits of the program.

Therefore, NCSC will urge Congress to find other ways of funding the Catastrophic Act, thus removing the additional financial burden from the backs of the elderly. This can be accomplished through the modification of the surtax, and substituting other revenues based more directly on traditional social insurance financing principles.

In addition, NCSC will support efforts to strengthen the so-called "maintenance-of-benefit" provision, which is intended to assure that employers pass along to retirees any savings they receive as a result of the expanded Medicare package. Although such savings to employers will be small this year, as the new Medicare benefits become fully phased in, the rebate to retirees will increase significantly.

The following resolution is recommended for action by the NCSC General Board:

NCSC General Board Resolution

Catastrophic Health Care

Public Law 100-360

WHEREAS NCSC members have expressed serious concerns about the method of financing the Medicare Catastrophic legislation because of its exclusive reliance on older people alone to pay the full costs of the bill; and

WHEREAS this legislation establishes a new and potentially dangerous precedent which deviates from the time-tested, traditional social insurance approach to financing Medicare benefits; and

WHEREAS NCSC continues to believe that the benefits of the legislation, when fully phased in, will be important improvements, particularly for those older Americans who are low-income and cannot afford private Medigap protection.

THEREFORE BE IT RESOLVED, That NCSC will pursue changes in the so-called "maintenance-of-effort" provision of the

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legislation which was designed to provide greater equity for those retirees already receiving catastrophic health care protection through employer- paid health care programs.

THEREFORE BE IT FURTHER RESOLVED, That NCSC will urge Congress to rethink the financing mechanism that is included in the Catastrophic Health Care initiative in order to remove an additional financial burden from the backs of the elderly; and

BE IT FURTHER RESOLVED, That NCSC will urge Congress to eliminate the Supplemental Premium and substitute other revenues based more directly on traditional social insurance financing principles.

BE IT FINALLY RESOLVED, That NCSC embark on a nationwide petition drive and other methods of communication urging Congress to amend the legislation along the lines suggested above.

STATEMENT OF JOE RODECAP, CHAIRMAN, COMMITTEE TO CORRECT INEQUITIES IN SOCIAL SECURITY AND MEDICARE

Senator HARKIN. Mr. Rodecap?

Mr. RODECAP. Thank you, Senator Harkin. I appreciate the opportunity to be here, and if I run over a tiny bit—one of my fellow members gave me a money clip this morning, and it's got a penny in it. I don't think this will help the Senator in Washington, DC, but maybe it might in Des Moines. One little penny in a money clip folded over off a pop can cover.

In studying the catastrophic health bill in 1988 and the benefits, I question that the average person will ever receive any benefits from this bill. As for the unlimited hospitalization, under the present DRG—that's the diagnosis related group—method of reimbursement and the peer review committee approval, it is difficult to be hospital confined for any length of time. Rather, patients are often dismissed from the hospital before they are well enough to be dismissed.

Prior to this year, a person under Medicare had 60 nonrenewable reserve days which could be used for the major or often terminal illnesses. This, in most instances, would be the time needed by a patient for a long or catastrophic illness. It is estimated that only 1 in 32 will ever receive any of the new hospitalization benefits. In 1988 100 percent of the cost of the first 20 days after a 3-day prior hospitalization confinement in a skilled nursing facility were covered by Medicare. In 1989 the patient must pay $25.50 a day for the first 8 days of confinement in a skilled nursing facility. The national average confinement in the nursing facility, skilled nursing facility, is 8 days, so it's about equal.

The home health care service is definitely needed, but not enough people are trained to render this service. This service could help people in their homes longer and help keep the medical costs down, the hospice care is also a much needed service. There is one problem, who will pay the bill?

The part B of the catastrophic insurance, which covers doctors' services, outpatient hospital services, home health care, and various medical services will be available in 1990, not 1989, only after the deduction of $1,370 has been met. $1,370 has to be met before you get any benefits. This is the $75 part B deduction and a bal-

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ance of another $1,295, which is 20 percent not paid by Medicare on the approved charge. This would mean one would have to incur expenses totaling $6,550 before Medicare catastrophic insurance would pay 100 percent of all approved charges for the remainder of the year, or a calendar year.

The drug benefits become available in 1990, even though the increased premium for catastrophic insurance is being paid in each month of 1989. The deductible will be $550 in 1990, and the drug benefits will be paid on approved generic drugs, approved generic drug charges established by Medicare. The deductible will go up in 1990 to 600 and again up in 1992 to $652. Because of the deductible adjustment each year, it is estimated that only 7 percent of the people will benefit from the provision, which is a very small benefit for the average person.

We also know our Medicare premium was increased from $24.80 in 1988 to, in 1989, $31.90. This is $7.10 that had previously been mentioned, or a 28.6-percent increase, which is a rather high increase. In addition to the premium increase, a surcharge, which has been mentioned earlier, of $22.50 for every $150 of income tax liable to the maximum of $800 for a single person or $1,600 for a married couple to be paid in 1990, that's on 1989's income that you pay a tax on. If the $22.50 isn't enough, the surcharge of $40.50 by 1993, or nearly one-third of each $150. Keep in mind, if one pays income tax on an estimated basis, it is necessary to include the payment for the surcharge in estimating your base or receiving a penalty in 1989 because you didn't turn it in.

One thing that upsets me, many tell me about it also, about a surcharge, is the fact we are encouraged to invest in, as we were told many years ago and still are encouraged, IRA's to use as a nest egg for our retirement when our income tax would be lower or not as much for a senior citizen on a fixed income. Now, when we use our IRA'S, we not only pay a tax, but the surtax.

Many in our income bracket of Social Security never receive any of or very little increase beyond additional Medicare premium increase yet. They pay the same for a kilowatt of light or a cubic foot of gas or the same price for food at a grocery store or a restaurant. So many out there don't get much increase. There are many nursing home insurance policies available, but with all of these other taxes, few are available to afford the nursing home insurance. If one could afford nursing home insurance, it would help keep one from spending all of their resources and ending up on Medicaid. Another important item in nursing home care, premiums are not a deductible on our income tax.

Other seniors tell me they still have no protection against a devastating cost of long-term custodial care. Congress would have done a great service for the elderly by directing once limited resources toward this most catastrophic care expense, namely home nursing care. The 1986 Tax Reform Act increased the tax rate by 28 percent before, and now the new law, on a very large segment of the American population.

The seniors of today learned as young people to lay away and save for a rainy day. They are now being taxed unfairly. Congress had stolen from the people born in 1917 through 1921 by cutting their Social Security benefits because of the action taken in 1969,

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the Social Security trust fund was placed in the Federal budget. This leads me to a report from a Congressman Neal Smith in this area in his March congressional letter:

Also I discovered that most people think the trust funds refer only to the Social Security retirement trust fund, but that is not so. In fact, other funds considerably exceed the amount in the Social Security retirement trust fund account. Other trust funds include: The highway, the airport, the military, Medicare, civilian retirement, and unemployment trust funds. In the past 10 years the accumulation of funds in the Social Security retirement trust fund has increased on the average of $6.92 billion per year, while the increase in other funds has averaged $31.37 billion per year.

Money is borrowed from the Social Security trust fund with little hope of it being paid back.

Now, my friends, how do you look upon what we have been paying for so many years, and now our elected officials are asking us American citizens, senior citizens, to pay for the catastrophic health bill? I call it a catastrophe.

Thank you, Senator Harkin, for this opportunity to express the feelings of thousands of our friends on this important issue. I have a few ideas that might spread the cost out, and I'd like to add a little comment beyond the speech here that I typed out. In reference to the editorial, I didn't read all of that editorial, but a friend received a letter from an editor of the Des Moines Register earlier. I'll tell you folks: In that letter it implied that we people who are complaining a little bit are very rich. I'm sorry, folks, I didn't feel I was in that category.

[The statement follows:]

STATEMENT OF JOSEPH RODECAP

In studying the Catastrophic Health Bill of 1988 and the benefits, I question that the average person will ever receive any benefits from this bill.

As for unlimited Hospitalization, under the present, "D.R.G., Diagnosis Related Group", method of reimbursement, and the Peer Review Committee approval, it is difficult to be hospital confined for any length of time. Rather, patients are often dismissed from the hospital before they are well enough to be dismissed. Prior to this year, a person under Medicare had 60 nonrenewable reserve days which could be used for major and often terminal illnesses. This in most instances would be time needed by patients for a long or catastrophic illness. It is estimated that only 1 in 32 will receive any of the new Hospitalization benefits. In 1988, 100 percent of the cost for the 1st 20 days after a 3 day prior hospital confinement in a Skilled Nursing Facility were covered by Medicare. In 1989 a patient must pay $25.50 per day for the first 8 days of confinement in a Skilled Nursing Facility. The National average confinement in a Skilled Nursing Facility is 8 days.

The Home Health Care Service is definitely needed, but not enough people are trained to render this service. This service could keep people in their homes longer, and help keep medical costs down. The Hospice care is also a much needed service. There is one problem, who will work at this wage.

The Part B of Catastrophic Insurance which covers Doctors' Services, outpatient hospital services, home health care and various medical services, will be available in 1990 only after the deductible of $1,370 has been met. This is the $75 part B deductible and a balance of $1,295 which is the 20 percent not paid by Medicare on approved charges. This would mean one would have to incur expenses totaling $6,550 before Medicare Catastrophic Insurance would pay 100 percent of all approved charges for the remainder of the year, or calendar year.

The Drug benefit becomes available in 1990, even though the increased premiums for Catastrophic Insurance are being paid in each month of 1989. The deductible will be $550 in 1990 and drug benefits will be paid on approved generic drug charges, established by Medicare. The deductible will go up in 1990 to $600 and up again in 1992 to $652. Because of the deductible adjustment each year, it is estimated that only 7 percent of people will benefit from this provision, which is a very small benefit for the average person.

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We all know our Medicare premium was increased from $24.80 in 1988 to $31.90 for 1989. This is $7.10 or amounts to 28.6 percent increase, a rather high increase. In addition to the premium increase, a surcharge of $2.50 for each $150 of income tax liability to a maximum of $800 for a single person or $1,600 for a couple is to be paid in 1990. If $22.50 isn't enough, the surcharge increases to $40.50 by 1993 or nearly one-third of each $150. Keep in mind, if one pays income tax on an estimated basis, it is necessary to include payment for the Surcharge. After 1989, one will be subject to a penalty by the IRS for not including the additional Surcharge in their estimated tax payment.

One thing that upsets me, (many tell me) about the Surcharge, is the fact we were encouraged to invest (and still are) in IRA's to be used as a nest-egg for retirement, when our income tax would be lower for Senior Citizens, on a fixed income. Now, when we use our IRA's we not only pay a tax but a sur-tax.

Many in the lower income brackets for Social Security never receive any or very little increase beyond the additional Medicare premium increase. Yet they pay the same for a kilowatt of light or the same for a cubic foot of gas to heat the home and the same price for food in either the grocery store or restaurant.

There are many nursing home Insurance Policies available but with all these other taxes few are able to afford Nursing Home Insurance. If one could afford nursing home insurance, it would help keep one from spending all their resources and ending up on Medicaid. Another important item is Nursing Home Care premiums are not a deductible item for income tax.

Other reasens Seniors tell me, they still have no protection against the devastating cost of long-term custodial care. Congress could have done a great service for the elderly by directing ones limited resources toward this most catastrophic care expenses, namely Nursing Home expense. The 1986 Tax Reform Act increased tax rates by 28 percent before and now added the new law on a very large segment of the American population.

The Seniors of today learned as young people to lay way or save for a rainy day. They are now being taxed unfairly. Congress has stolen from the people born in 1917 through 1921, by cutting their Social Security Benefits. Because of the action taken in 1969, the Social Security Trust Fund was placed in the Federal Budget. This leads me to a report from Congressman Neal Smith in his March Congressional letter and I quote, "Also, I have discovered that most people think "trust funds" refer only to the Social Security Retirement Trust Fund, but that is not so. In fact, other funds considerably exceed the amount in the Social Security Retirement Trust Fund account. Other trust funds include: highway and airports; military retirement; Medicare; civilian retirement, and unemployment trust funds. In the past ten years, the accumulation of funds in Social Security Retirement Trust Fund has increased on the average of $6.92 billion per year, while the increase in the other funds has averaged $31.37 billion per year," end quote. Money is borrowed from the Social Security Trust Fund, with little hope of it being paid back.

Now my friends, How do you look upon what we have been paying for so many years, and now our elected officials are asking us as American Senior Citizens to pay for this Catastrophic Health Bill. I call it a, "Catastrophe."

Thank you Senator Harkin for this opportunity to express the feelings of thousands of Iowa friends on this important issue.

Mr. RODECAP. Thank you, Senator Harkin.

Senator HARKIN. Mr. Seeber, in the resolution adopted by the National Board of the Council of Senior Citizens, there's a call for Congress to eliminate the supplemental premium and "substitute other revenues based more directly on traditional Social Security insurance financing principles." What does that statement really mean?

Mr. SEEBER. Well, it very simply means that in all of the Social Security programs, everybody pays, and when they need the benefits, everybody shares. Here we have a departed—in my opinion, a very dangerous precedent in the fact that only the elderly pay, and certainly all I'm saying is let's share those costs among the entire population; it could be done in a number of ways. Senator Pepper suggested on the home health care bill that he tried to pass last year to raise the amount of Social Security that people pay over the limit now and use that additional money to fund health care

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for seniors, which would mean that, in that case, only the very affluent would pay that.

Senator HARKIN. In other words, what you're saying is raise the cap that's now capped at $48,000?

Mr. SEEBER. That's correct. That was one way that was suggested last year to pay for these benefits, because when you reach that level now, you stop, you don't pay if you make $100,000 or so on. I never reached that level, but, nevertheless, that's one way.

Senator HARKIN. The figures I've been told are that if you raise the cap—do you all know what we're talking about?

THE AUDIENCE. Yes.

Senator HARKIN. That if you do away with the cap, we could raise somewhere in the neighborhood of about $10 billion a year.

Mr. SEEBER. I don't know. I don't have the figures on the cost, but I just know that for the first time in my memory in this country we have said to one particular segment of the population that you will bear the entire cost of a particular program. And that's certainly different than the way we've been doing things for the last 50 or 60 years; it's unfair to the elderly and in response to what Joe brought up, about a year or so ago I responded to an editorial to the register, one of their writers called us greedy senior citizens. I'm sure we have a lot of greedy senior citizens, just like we have a lot of greedy people in the normal population. We also have senior citizens who they'd help out there, and that's things we're trying to do when we pass that legislation is give help where it's really needed.

Senator HARKIN. Mr. Rodecap, there has been a lot of confusing information that's come out about the cost of Medicare catastrophic care coverage, what it will be and who it will benefit. Obviously in the best of all possible worlds no one would face a catastrophic illness, so they wouldn't need the benefits. In fact, I was going back through your testimony here—let me just go back here and look at it. I was reading it last night, and you pointed out that only 7 percent of the people will benefit from this provision. I guess that's just the drug provision, but basically, you're pointing out that you don't feel that most people would benefit, really, from the catastrophic care bill. Is that right?

Mr. RODECAP. This is right. There's nothing there as far as the home nursing care. Eighty hours per year, folks, you bear that down a tiny bit and you figure it out for how it goes per week, and it's only about 1 hour and 20 minutes or less than 15 minutes per day. That is not very much, and yet they kind of gloat. They'll say that 80 hours per year is a benefit, and I don't think that's very much. And that's one of the few benefits that they talk about.

Senator HARKIN. It is estimated that when the benefits are fully phased in by 1993, 22 percent of Medicare enrollees will receive some benefit each year. That's 1 out of 5 will receive some benefit each year with a majority of seniors, using the benefits at some point during their lifetime.

Mr. RODECAP. I would say they are forgetting the point that these benefits have to meet the Medicare guideline, and at the same time—as far as the benefits, some of these are the generic drugs. And the doctors and the peer review board boots people out of the hospital before they're ready. I just had a call last night from a

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party who is having to leave the hospital today from gallbladder surgery this past Friday, folks. Wait a minute. Where do we stand on this with our hospitals?

Senator HARKIN. Let me point this out: Part A catastrophic hospital benefits are kicked in this year. Prior to this year, if you had to go back to the hospital repeated times during the year, you had to pay a deductible each time.

Mr. RODECAP. This is right.

Senator HARKIN. Now, I understand what you're saying, and I have a sense about these DRG's putting people out of this hospital too soon. I know that, and I hope something can be done about that. But this year, under the new catastrophic care bill, if you have repeated visits to the hospital, you only pay one deductible every year.

Mr. RODECAP. This is right.

Senator HARKIN. So you tell me which is best: Paying it every time you go back or paying it once a year?

Mr. RODECAP. But in order to get any benefits you will have to incur a liability from the doctor and all in excess of $6,550. That 20 percent only amounts to $1,375, so you've got to pay that before you receive the Medicare benefit on approved charges.

Senator HARKIN. That's part B. That's not part A. That's doctor bills.

Mr. RODECAP. That's doctor bills, yes.

Senator HARKIN. I'm talking only about part A, in terms of hospitals. Prior to this year, if you had to go to the hospital several times during the year, which many elderly do, they had to pay a deductible every time. This year, you will only pay one deductible, and you go back to the hospital as many times as you have to go back to the hospital.

Mr. RODECAP. I'll accept this, but at the same time, $560 one time. But if you should happen to end up in there at a year's end out with over $1,375 and then your hospital on top of it, you will find that you don't get in the hospital to get very much benefit on your second, third, or fourth days because they've got you out of the hospital.

Senator HARKIN. I understand you're getting discharged sooner.

Mr. RODECAP. That's right.

Senator HARKIN. All I'm saying is that—assuming that we're not doing anything about the DRG's—which would be best: The present catastrophic care system or what we had before?

Mr. RODECAP. I think that the people are leaving the hospital before they're ready, so I would say maybe they have drawn this noose down a little bit too tight on the peer review board, and it's time—when people are leaving and then have to go back 2 or 3 weeks later for some additional attention——

Senator HARKIN. So you're saying we should focus our attention on the DRG's; that's what you're saying?

Mr. RODECAP. Yes.

Senator HARKIN. Second, I'd like to clear up something from testimony about cost. You said that a person would have to ex[illegible] totaling $6,550 before Medicare catastrophic insurance would pay 100 percent of all approved charges. Prior to Medi-

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care catastrophic coverage under part B, a beneficiary had to meet an annual $75 deductible——

Mr. RODECAP. That's right.

Senator HARKIN [continuing]. And then pay 20 percent of the 100 percent limit with no cap on how high the bill went.

Mr. RODECAP. You do have to pay the—as far as the hospital, your $560.

Senator HARKIN. Let's not confuse the two. We're talking about part B because you said they had to incur expenses of $6,550. I'm just saying before catastrophic, under part B, you had to pay a $75 deductible plus a 20-percent coinsurance without any cap.

Mr. RODECAP. Right.

Senator HARKIN. All right. Under catastrophic now, there's a limit of $1,370 that anyone would have to pay for part B services.

Mr. RODECAP. On approved charges.

Senator HARKIN. So didn't you mean that a person would generate $6,550 in costs, not out-of-pocket expenses?

Mr. RODECAP. That's his cost.

Senator HARKIN. But that is not out-of-pocket expenses. I wanted to clear that up. In your statement, you said it was expenses; it's cost, not expenses.

Mr. RODECAP. Right.

Senator HARKIN. So as a result of this change, isn't part B going to be especially worthwhile for people who have especially high doctor bills?

Mr. RODECAP. It could be, to a degree. But how many people get in there to the point that they have used up all—it's only a very few people that will live that long to use up the—bring it into the catastrophic condition. That's why I say there's only about 6 to 7 percent who get long-term care out of that.

Senator HARKIN. Let's clear that up. Do you have fire insurance for your house?

Mr. RODECAP. I do have.

Senator HARKIN. Do you know that less than one-half of 1 percent of the American people will ever have a fire that burns their house? Do you know that means that 99.5 percent of the American people will never have a fire? So why have fire insurance on your house? I'll tell you why. You have fire insurance because if a fire ever burned your house down, the loss would be so catastrophic that you could never make it up. And so what I'm saying is that catastrophic is like fire insurance. Of course, not everyone is going to use it, but if you ever had a catastrophic illness, the cost would be so enormous that it could wipe out all of your savings and everything else.

Mr. RODECAP. I can acknowledge your comment there, and I would say it this way to you. The one thing I'll respond to that comment is that—folks, all of us that were employed or self-employed, that includes most of us, paid into a FICA for our benefits as a retirement and by action of Congress in 1969, putting the Social Security into the Federal budget. And then in 1977 we people were denied the benefits that we paid for. And if we had a $10,000 life insurance, and we died 1 year or 2 years or 20 years after we had taken out the life insurance, the heirs would receive that. But we were denied, in 1917 through 1921, our FICA that we

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paid for. And then in 1983 Congress got benefits of all people born after 1921 for the FICA that they paid for, which was a supplemental insurance. And I'll answer you the same way, that as far as the fire insurance, I have our car insurance, and I haven't collected on the car insurance in over 25 years.

Senator HARKIN. Well, as I was saying, again, catastrophic health care was just to cover the possiblity of a catastrophic illness happening to someone. Obviously we hope that it doesn't happen to anyone, and the fewer that it happens to, the better off we're all going to be. But we have gotten so many reports from people who had a catastrophic illness one time that wiped out their life savings. And there was a hue and cry from senior citizens all over the country to have catastrophic health care.

Again, I'm willing to discuss the possibility of different financing mechanisms, but the one thing that bothers me is if people say only a few people benefit from it, therefore, we shouldn't have it. Again, it's an insurance policy, and the more people that are in it, the cheaper it is for everybody else. Since it covers everyone, then it is, indeed, an insurance policy. You may collect; you may not collect. If you don't collect, that's wonderful. I paid car insurance all of my life, and I don't think I've ever collected, but I still pay it anyway, because obviously if something happens, I want the insurance to pay for it. So if it's just the argument that just a few will collect off of it, we know that. But there are those few that need that kind of coverage, and obviously all of us pay in to keep the cost down.

As I mentioned earlier, the Senate Finance Committee has agreed to hold hearings and look at the financing mechanism. We'll be looking into alternatives on how it can be financed. Now, in light of the budget deficits and the position of the President that there will be no new taxes, it's going to be extremely difficult to come up with a proposal. So I say to you and others who will testify today that we're looking for suggestions that would allow us to maintain the benefits and not place an unfair burden on the poor elderly. We need your help in coming up with those suggestions. One was made by Mr. Seeber, and that was to raise the cap.

Mr. RODECAP. I had that as one of my comments too, and I feel that we paid for FICA and if it's been used in other places, let's use some of it to help take care of this financing for the catastrophic health bill.

Senator HARKIN. I'd like to find some way, but I'm saying we need suggestions. Raising the cap does raise taxes, but it raises it on the upper income people, so that doesn't bother me all that much.

Mr. RODECAP. Many of the people out there have supplemental insurance over and beyond Medicare, and we don't even get a chance to take that off as a deductible item on our tax base. And at the same time, they've eliminated many items on our tax deductible items from us that—no, we're not raising taxes, but, no, you don't have the deduction items either.

Mr. SEEBER. Well, let me comment on that. The private insurance companies, the Blue Cross, the Aetna, others, as a result when all of the benefits from the catastrophic kick in, those supplemental premiums ought to go down very sharply. You shouldn't

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have to be paying the kind of insurance that you're paying now because many of those benefits that the old law didn't cover will be covered now. So those costs should go in the next 2 or 3 years.

Senator HARKIN. We're anticipating the medigap premiums will not rise as rapidly, and different plans will be in from the private insurers to reflect that.

Mr. RODECAP. We don't get any benefits from our expended insurance; this we bought for ourselves. And those of us that are paying for health insurance, we don't get deductions on that anymore. These are some of the little benefits that hurt when you raise the Medicare costs and then put the surtax on top of us.

Wait a minute. When a person is only getting $300 a month—and I happen to be getting a little more than that, but I get letters from those people. Those people didn't get an increase on their Social Security for the simple reason that the Medicare costs ate up the expense yet their kilowatt, gallon of gas, they're all the same.

Senator HARKIN. It is my understanding that 40 percent of the elderly will pay something on the supplemental premium, but that 60 percent of the elderly will pay no supplemental whatsoever.

Mr. RODECAP. For the same reason that many of them—I've gotten letters, and I've turned in letters to different organizations, AARP is an example, that these people that only get $260, paying $70 for rent to live and trying to live on what's left it is difficult. And then with these premiums going up as far as—like they did this year, hey, wait a minute. The dollar don't stretch. In Washington it's made of rubber, but not here in Iowa. Our legislators think it is. [Applause.]

Senator HARKIN. But for those elderly, they won't have to pay anything extra.

Mr. RODECAP. There is some of the elderly that will not. And there's one thing. I'm sorry to see these people in the county homes, and yet, again, we've got nursing homes to help maintain these people, and they've used up all of the money they have, they're on title XIX, and we're all paying for that, folks.

Senator HARKIN. Do you have anything else?

Mr. RODECAP. I appreciate this opportunity.

Senator HARKIN. I appreciate your being here, both of you, and your fine testimony.

Mr. SEEBER. One more point. I certainly agree with Joe on the DRG. This is something that really needs to be investigated by Congress because old people are being shoved out of the hospitals before they should be, no question.

Senator HARKIN. Thank you, very much.

Our second panel this morning consists of Ms. Shirley Henderson, senior advocate for the Heritage Agency on Aging; Lonnie Conger, president of the Iowa Federation of Chapters of the National Association of Retired Federal Employees; and Mr. Robert Jackson, Sr., the manager of the Minorities Outreach Project for the Union Missionary Baptist Church in Des Moines.

If you will summarize your statements in 5 minutes, I'd appreciate it, and then we can get into questions and answers. Time is running by.

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WOMAN IN AUDIENCE. Senator, can we stand and stretch? We've been sitting for a long time.

Senator HARKIN. Why don't we take a 5-minute recess.

[A brief recess was taken.]

STATEMENT OF SHIRLEY HENDERSON, SENIOR ADVOCATE, HERITAGE AGENCY ON AGING

Senator HARKIN. The subcommittee will come to order. Thank you very much. Why don't I introduce Shirley Henderson, senior advocate for the Heritage Agency on Aging.

Ms. HENDERSON. Senator Harkin, I would like to thank you for giving me the opportunity to share my perspective on the Medicare Catastrophic Health Care Act as it pertains to the long-term area. During my testimony, I would address two positive and one negative aspect of the act.

In my position as a senior advocate for the Heritage Agency on Aging, I spend a great deal of time with clients concerned about long-term care and health issues in general. The primary issues are financing long term care, nursing home placement and complaints, and hospital discharge orders as they relate to Medicare diagnostic related groups [DRG's].

During the past several years, I have stood by helplessly and watched elderly couples who thought they had planned well for their retirement struggle with the fact that their joint life savings have been depleted to pay for nursing home care. It is difficult to comprehend the trauma and stress a spouse experiences when attempting to work through the financial maze of paying for the care of a spouse in a nursing home, while also struggling with her own financial welfare. I am troubled by the fact that a spouse in the community will not go to the doctor, buy prescription drugs, have their eyes checked, buy new clothes, or repair the roof on their house for fear of not having enough money to pay the nursing home. I have heard more than one spouse say: "I feel so guilty to even think about it, but what's going to happen to me when the money is all gone?"

The Catastrophic Health Act will address this concern, and I won't go into detail on it, I'm sure that, Senator Harkin, you're already aware of this. But you may not be aware of the fact that the older Iowan's legislature priority bill this year is asking the State legislature to increase the minimum from $12,000 to $60,000 of what a spouse can retain. The amount set will be determined by how much it will cost the State and what the legislature feels the Iowa taxpayer can afford.

Another important section of the act which I feel very positive about provides additional services and benefits to individuals who require long-term home health care. As you may know, in Iowa the Heritage Area Agency on Aging has been in the forefront to establish a case management program. This program provides community-based services to the frail and vulnerable elderly in order to prevent inappropriate institutionalization. Case management is a system which provides in-home services as a long-term care alternative. And this may be something we should be looking at as far as costs. We have a very successful case management program in Linn County and are very pleased to learn the Medicare Cata-

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strophic Health Act will: Increase the number of days Medicare will pay for home health care; two, provide funding for outpatient prescription drugs; three, extend the hospice care; four, provide for additional in-home respite services. These benefits will enhance our efforts to provide Iowa's frail elderly with long-term care alternatives. As I stated earlier, I do have a negative perspective on the Catastrophic Health Act to share with you.

I am often asked to counsel and advise families who have just been notified by hospital staff that a loved one no longer requires acute hospitalized care and must be transferred to a nursing home.

The family is usually given 1 to 3 days to locate a nursing home. If the patient is low income and qualifies for title XIX, the State will reimburse nursing homes for the cost of care; however, because many nursing homes feel that the State reimbursement rate is unacceptable, they are very reluctant to accept title XIX residents. Compound that with a resident that requires a higher level of care, and you have a resident with very limited choices. Cedar Rapids residents facing this type of situation are discharged from local hospitals to nursing homes in communities as far away as Waterloo, Independence, Manchester, and Dysart. Why? Because nursing homes in this community are not available to them. At this point the resident has lost control of his or her life.

This problem created a devastating situation, not only for the resident but the family. The resident is moved to an unfamiliar community and is completely dependent on those who provide the care. Family members, because of the distance, other family and work commitments, and/or health problems, are not available to monitor the quality of life of this resident. When I become involved in this type of situation, I see the resident and family emotionally and physically drained and completely frustrated.

I'm sure many of you in the audience today have faced a similar situation; I know I have. The decision to discharge a patient from the hospital is based on Medicare DRG'S. Medicare determines the number of days a patient will remain in the hospital. If a patient is kept longer, Medicare will not reimburse the hospital. It is important to note that according to the Health Care Finance Administration, the average hospital stay for a Medicare recipient is 9.3 days.

Although the Medicare Catastrophic Health Act provides for unlimited hospital stays, only a small minority of Medicare recipients qualify. How many Medicare recipients will actually spend more than 2 weeks in a hospital? Not many. Where will they go? The majority that require additional care will be transferred to nursing homes.

The Medicare Catastrophic Coverage Act provides for additional coverage for those requiring skilled care, but my concern is that Iowa has few residents residing in skilled facilities. According to the State department of human services, the State of Iowa has now approximately 800 persons residing in skilled facilities compared to 31,000 residing in intermediate facilities.

Senator Harkin, this does not fully address this issue. Iowa has 31,000 residing in intermediate health care facilities, and I recommend that on behalf of these individuals that you place long-term care high on your list of priorities.

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In conclusion, the Medicare Catastrophic Health Act may not be the complete answer to health and long-term care issues affecting many of us today, but there is some substance in the act. Congress is now comtemplating some of the amendments to the bill, which I support, but this process will place the bill in a very, very vulnerable position. When a piece of legislation is revised, there is always a danger that some of the most beneficial sections could be lost in the process.

Senator Harkin, I would like to take this opportunity to emphasize that we must stay alert if potential amendments to the catastrophic act are considered. We certainly do not want to throw out the baby with the bath water.

[The statement follows:]

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STATEMENT OF SHIRLEY HENDERSON

Senator Harkin I would like to thank you for giving me the opportunity to share my perspective on the Medicare Catastrophic Health Coverage Act as it pertains to long term care. During my testimony I will address two positive and one negative aspects of the Act.

In my position as Senior Advocate for the Heritage Area Agency on Aging, I spend a great deal of time with clients concerned about long term care and health issues in general. The primary issues are financing long term care, nursing home placement and complaints, and hospital discharge orders as they relate to Medicare Diagnostic Related Groups (DRG's).

During the past several years, I have stood by helplessly and watched elderly couples, who thought they had planned well for their retirement, struggle with the fact that their joint life savings have been depleted to pay for nursing home care. It is difficult to comprehend the trauma and stress a spouse experiences when attempting to work through the financial maze of paying for the care of a spouse in a nursing home while also struggling with his/her own financial welfare. I am troubled by the fact that a spouse in the community will not go to the doctor, buy prescription drugs, have their eyes checked, buy new clothes or repair the roof for fear of not having enough money to pay the nursing home. I have heard more than one spouse say "I feel so guilty to even think about it, but what is going to happen to me when the money is all gone?"

The Catastrophic Health Act <u>will address</u> this concern. Effective October 1, 1989 the spouse of a Medicaid-covered nursing home resident will be allowed to retain more income and assets when the assets are in the name of the institutionalized spouse. The spouse remaining in the community may retain a minimum of $12,000 or half the total assets, whichever is greater, but not more than $60,000 and individual states do have the option to increase the minimum to any amount up to $60,000.

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Senator Harkin you may be interested in the fact that the Older Iowan's Legislature's priority bill this year is asking the state legislature to increase the minimum from $12,000 to $60,000. The amount set will be determined by how much it will cost the state and what the legislature feels Iowa Taxpayers can afford.

Another section of the Act which I feel very positive about provides additional services and benefits to individuals who require long term home health care. As you may know, in Iowa the Heritage Area Agency on Aging has been in the forefront in establishing a "Case Management" Program. This program provides community-based services to the frail and vulnerable elderly in order to prevent inappropriate institutionalization. Case Management is a system which provides in-home services as a long term care alternative. We have a very successful Case Management Program in Linn County and are very pleased to learn the Medicare Catastrophic Health Act will: (1) increase the number of days Medicare will pay for home health care, (2) provide funding for outpatient prescription drugs, (3) extend the hospice care and, (4) provide for additional in-home respite services. These benefits will enhance our efforts to provide Iowa's frail elderly with long term care alternatives. As I stated earlier, I do have a negative perspective on the Medicare Catastrophic Health Act to share with you.

I am often asked to counsel and advise families who have just been notified by hospital staff that a loved one no longer requires acute (hospital) care and must be transferred to a nursing home.

The family is usually given one to three days to locate a nursing home. If the patient is low income and qualifies for Title XIX, the state will reimburse nursing homes for the cost of care. However, because many nursing homes feel that the state reimbursement rate is unacceptable, they are very reluctant to accept Title XIX residents. Compound that with a resident that requires a higher level of care and you have a resident with very limited choices. Cedar Rapids residents facing this type of situation are discharged from local hospitals to nursing homes in communities as far away as Waterloo,

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Independence, Manchester and Dysart. Why? Because nursing homes in this community are not available to them. At this point the resident has lost control of his/her life.

This problem creates a devastating situation not only for the resident but, the family. The resident is moved to an unfamiliar community and is completely dependent on those who provide the care. Family members because of the distance, other family and work commitments and/or health problems are not available to monitor the quality of life of this resident. When I become involved in this type of situation I see the resident and family emotionally and physically drained and completely frustrated.

I am sure many of you in the audience today have faced a similar situation. The decision to discharge a patient from the hospital is based on Medicare (DRG's). Medicare determines the number of days the patient will remain in the hospital. If the patient is kept longer Medicare will not reimburse the hospital. It is important to note that according to the Health Care Finance Administration Statistic Research Division, the average hospital stay for a Medicare recipient is 9.3 days.

Although the Medicare Catastrophic Health Act provides for unlimited hospital stays, only a small minority of Medicare recipients qualify. How many Medicare recipients will actually spend more than two weeks in a hospital? Not many. Where will they go? The majority of those still requiring additional care will be transferred to nursing homes.

The Medicare Catastrophic Health Coverage Act provides for additional coverage for those requiring skilled care, but my concern is that Iowa has few residents residing in skilled facilities. According to the State Department of Human Services the State of Iowa now has approximately 800 persons residing in skilled facilities compared to 31,000 residing in intermediate facilities.

Senator Harkin, the Medicare Catastrophic Health Coverage Act does not fully address this issue. Iowa has 31,000 individuals residing in intermediate care

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facilities, and I recommend, on behalf of these individuals, that you place long term care high on your list of priorities.

The Medicare Catastrophic Health Act may not be the complete answer to health and long term care issues affecting many of us today, but there is some substance in the act. Congress is now contemplating some amendments to the bill, which I support, but this process will place the bill in a very vulnerable position. When a piece of legislation is revised there is always the danger that some of the most beneficial sections could be lost in the process.

Senator Harkin, I would like to take this opportunity to emphasize that we must stay alert if potential amendments to the Medicare Catastrophic Health Act are considered. We certainly do not want to "throw out the baby with the bath water".

STATEMENT OF LONNIE CONGER, PRESIDENT, IOWA FEDERATION OF CHAPTERS OF NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Senator HARKIN. Lonnie Conger, president of the State of Iowa Chapter of the National Association for Retired Federal Employees.

Mr. CONGER. Thank you, Senator Harkin. I just wanted to say to you that I appreciate the opportunity to be a part of your older Iowans' task force also.

Senator HARKIN. I appreciate your willingness to serve on that.

Mr. CONGER. And also a lot of things that may come to mind. Cummings and so forth might relate to you and me.

Senator HARKIN. We'll discuss that later. I didn't know that. That's interesting.

Mr. CONGER. Thank you for the opportunity to testify regarding the National Association of Retired Federal Employees' position on the Medicare Catastrophic Coverage Act of 1988. We appreciate the concern of our lawmakers in Washington and feel that this piece of legislation is a catastrophe for the very people it was designed to help.

At our national convention in Little Rock, AR, in September 1988, those attending mandated the national officers, those living in Washington, the national office, to develop a position to advise those in Washington the impact on our membership. I want to relate what has been prepared for us to share with our people and our elected officials who represent us in Washington.

There are more than 28 million people eligible for part A of Medicare. Of this number it is estimated 45 percent will be liable for the new part A Medicare surtax.

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Among Federal retirees who are enrolled in our national employees health benefit program, 699,926 have both Medicare parts A and B, 58,587 have part A only, and 68,245 are enrolled only in part B. 174,346 Federal retirees have no Medicare coverage at all. These are figures that were compiled as of March 1988. In 1989 the maximum Medicare surtax of $800 will be paid by part A eligible Medicare individuals whose Federal income tax liability is at least $5,400. This roughly equals a taxable income of about $27,573. Married couples who are both Medicare eligible, whose tax liability is at least $10,800, which is roughly equal to taxable income of $52,384, will pay the maximum Medicare surtax of $1,600, or $800 each, in 1989.

In 1989 and the following years, the Medicare catastrophic surtax will be calculated as follows: In 1989, 15 percent, or $22.50, for each $150 in Federal tax liability; in 1990, 25 percent, or $37.50, for each $150 in Federal tax liability; in 1991, 26 percent, or $39, for each $150 in Federal tax liability; and 1990, 27 percent, or $40.50, for each $150 in Federal tax liability; in 1993, 28 percent, or $42, for each $150 in Federal tax liability.

This Medicare surtax, which begins at 15 percent and rises to 28 percent by 1993, gives the elderly the highest income tax rates in the country. Those who pay the surtax will, in fact, pay Federal income tax rates at 17.2 and 32 percent, rather than the current rates of 15 and 28 percent.

The maximum Medicare surtax, which is $800 for individuals in 1989, rises $50 per year to $950 in 1992 and to $1,050 for individuals by 1993. This amount is double the Medicare eligible couples.

The surtax penalizes the very people who may have sacrificed and saved for their retirement year by taxing income from savings and investments which may deprive them of income needs for support.

The new Medicare catastrophic benefits are designed so that a constant share of beneficiaries would be eligible for the benefits from the catastrophic limit each year. But the law, Public Law 100-360, dictates that only 7 percent of the average number of enrollees during the year may become entitled to benefits from the catastrophic part B coverage.

This law further states that only 16.8 percent of the average number of enrollees during a year will be able to benefit from the prescription drug coverage. And, in addition, only 7 to 16.8 percent of part B beneficiaries will be able to qualify for the respite care provisions due to having to meet either the part B catastrophic limit or the prescription drug deductible.

Long-term and custodial nursing home care is not covered under this legislation, despite the fact that it is by far the largest out-of-pocket expense most elderly ever face and can average $25,000 per person per year. Those elderly who do spend more than $2,000 in a year in out-of-pocket medical expenses—expenses not covered by insurance—spend 81 percent of that money on long-term care. In 1984 the Medicare covered only 2.1 percent of the nursing home costs of the Nation's aged.

It is widely speculated that for most Medicare-eligible individuals, this expansion of Medicare will provide less protection for more money than comparable benefits currently available to them.

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According to the Health Insurance Association of America, one-third of the Nation's elderly currently have catastrophic coverage as a fully paid benefit from their retirement plan and will gain nothing from the additional surtax and premium they pay. Approximately 70 percent of the Nation's elderly are already covered by private insurance policies against these expenses. Only 20 percent of the Medicare population has no other supplementary health insurance coverage.

After 1993 the law permits the surtax to be increased by 1 percent per year, or $1.50 per $150 of Federal income tax, to fund the catastrophic benefits. If that estimate still falls short, part B premium is then increased to shoulder the rest of the cost. This is a significant consideration when you note that many believe the surtax received will not be able to keep pace with the increasing costs.

We suggest that consideration be given to a Medicare part C. That part C would be optional and would permit nonparticipation for those without ample coverage under a fully paid benefit from their retirement plan.

Senator Harkin, there are some 125,000 Federal employees; in the State of Iowa, there are 32 chapters. I have visited with all 32 chapters during my time as president last year and most of them this year, and I get the same feedback from all of those: That we as Federal retirees, as you stated earlier, are being penalized on our income tax and likewise on our health benefits. For instance, they arranged for me to get about $4 a month reduction in my insurance premium for the privilege of paying $225 a year for catastrophic health care for myself.

Senator HARKIN. Thank you, Mr. Conger. I'm sorry. We have to get going. I was watching the clock on the wall, and it's been moving very slowly. It says a quarter to 10, and now I realize it's 10:20. We're going to have to go to Mr. Jackson and start moving. Mr. Jackson, will you proceed with your testimony.

[The statement follows:]

STATEMENT OF LONNIE CONGER

Thank you for the opportunity to testify regarding the National Association of Retired Federal Employees position on the Medicare Catastrophic Coverage Act of 1988. We appreciate the concern of our lawmakers in Washington but feel this piece of legislation is a catastrophe for the very people it was designed to help.

At our National Convention at Little Rock, Arkansas in September 1988 those attending mandated the National Officers to develop a position that could advise those in Washington the impact on our membership. I want to relate what has been prepared for us to share with our people and our elected officials who represent us in Washington.

There are more than 28 million people eligible for Part A of Medicare. Of this number, it is estimated that 45 percent will be liable for the new Part A Medicare surtax.

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This Medicare surtax which begins at 15 percent and rises to 28 percent by 1993 gives the elderly the highest income tax rates in the country. Those who pay the surtax will in effect pay federal income tax rates of 17.2 and 32 percent rather than the current rates of 15 and 28 percent.

The maximum Medicare surtax which is $800 for individuals in 1989 rises $50 per year to $950 in 1992 and to $1,050 for individuals by 1993. This amount is doubled for Medicare eligible couples.

The surtax penalizes the very people who may have sacrificed and saved for their retirement years by taxing income from savings and investments which may deprive them of income needed for support.

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It is widely speculated that for most Medicare-eligible individuals, this expansion of Medicare will provide less protection for more money than comparable benefits currently available to them.

According to the Health Insurance Association of America, one-third of the nation's elderly currently have catastrophic coverage as a fully paid benefit from their retirement plan and will gain nothing from the additional surtax and premium they pay.

Approximately 70 percent of the nation's elderly are already covered by private insurance policies against these expenses.

Only 20 percent of the Medicare population has no other supplementary health insurance coverage.

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We would suggest that consideration be given to a Medicare Part C. The Part C would be optional and would permit nonparticipation for those with ample coverage under a fully paid benefit from their retirement plan.

STATEMENT OF ROBERT JACKSON, SR., MEDICARE BENEFICIARY

Senator HARKIN. Mr. Jackson will you proceed with your testimony.

Mr. JACKSON. Senator Harkin, I'm Robert Jackson, Sr., the union Baptist majority outreach manager of the Union Missionary Baptist Church, and I'd just like to digress for a moment, and I won't repeat. What I'm looking at—and I would like to say this being an elderly minority outreach—I think there is only probably three minorities in this whole building, if it's that much. But I'd like to say one other thing away from my testimony: The minority outreach is working with the Area Agency on Aging to look and find those minority elderly that do not know about the benefits, what the bene-

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fits consist of. So we are working with them, and in the last 6 months we contacted about 1,500 minority elderly. Now, to go over to my testimony.

Senator HARKIN. OK.

Mr. JACKSON. I appreciate the opportunity to present this testimony today. We have not heard a lot of comments and concern about the minority elder. First of all, we applaud the additional benefits the Catastrophic Protection Act provides as a step in the right direction. Senior citizens and those who work closely with them that have long known that Medicare, although an essential program, has some major gaps, this legislation began to close some of those gaps. We are especially pleased to see, for the first time, the inclusion of outpatient prescription drugs.

We have worked closely with many minority seniors where prescription drugs are a major expense. It is a step in the right direction to recognize prescription drugs as the majority health care expense, which they are.

We don't agree with those who say that few seniors will benefit from this legislation. Approximately 20 percent of Medicare recipients will collect benefits from the act when all phases are implemented. We feel it is important to stress the insurance aspect of Medicare catastrophic coverage by definition is: To help the relative small number of individuals who will experience catastrophic medical expense. The basic concept of insurance is to spread the risk over a large group and make it affordable for everybody. Catastrophic protection is like other insurance. Most people hope they will never have to benefit from their auto or fire insurance policies. The act provides increased respite care, that's good. Home health care, that is good. And perhaps most importantly, it provides for a decent standard of living for spouses or institutional seniors.

The spouse impoverishment provision will ease the worry of at least many minority health seniors. We strongly support a comprehensive long-term care bill while recognizing that it is a very complicated and expensive proposition which will require some time to develop and implement. We firmly believe that the 7 million elderly that need long-term care should receive these benefits as they have in the past and will do so in the future.

We will work and lobby like we have in the past and will do so until a very important need is met. Now I say lobby, but we will talk and we will discuss with those that are in the powers that be to see that this need is being met. Our biggest concern with the Catastrophic Act is the way it is financed. We believe the financing is unfair. We do not object to progressive means of financing these benefits under which wealthy individuals are required to pay more than the poor; nor do we object to the financing mechanism which provides a substitute to the lower income person. And in this State there is some help because they are involved in Medicaid paying some of that.

But we do object to the basic principles underlying the mechanism which was chosen to finance the benefit; namely, that the benefits would have to be paid for entirely by the elderly. This principle was incorporated in the act by former President Reagan, and, as you stated before, to get the bill passed, you had to do some compromise. And being an old union man myself, I understand

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that we must get something and then start working ahead to what we have, so we are strongly encouraged about the bill.

Many members feel requiring the elderly to pay for the entire cost of the catastrophic benefit is wrong for several reasons: Most important, it violates the basic social insurance principles which have formed the base for our Social Security and Medicare. This could establish a dangerous precedent for undermining these programs in the future; furthermore, the net result is the middle and upper class seniors have to shoulder the entire burden of paying for the subsidies for the lower income elderly. This burden should properly be shared by all of society, not just the more fortunate segment of the elderly, because all of us will benefit sooner or later.

We do not support repeal of this legislation, given that the legislation includes an important expansion of benefits. We do not, so to speak, want to throw the baby out with the bath water. We do strongly urge Congress to find other ways of funding the Catastrophic Act; thus, removing additional financial burdens on the backs of the elderly. This should be done instituting other revenues based more directly on traditional social insurance financed in the principle. Again, Senator, I'm very thankful for having the opportunity of discussing this and presenting our side to you. Thank you.

[The statement follows:]

STATEMENT OF ROBERT A. JACKSON

Senator, I am Robert A. Jackson, Sr., the Union Baptist Minority Elderly Outreach Project Manager of Union Missionary Baptist Church, Des Moines, Iowa.

I appreciate the opportunity to present testimony on this very important issue. It is one we have heard a lot of comment and concern about among the minority elderly.

First of all, we applaud the additional benefits which the Catastrophic Protection Act provides as a step in the right direction. Senior citizens and those who work closely with them have long known that Medicare, although an essential program, has some major gaps. This legislation begins to close some of those gaps.

We are especially pleased to see, for the first time, the inclusion of out-patient prescription drugs. We have worked closely with many minority seniors for whom prescription drugs are a major expenses. It is a step in the right direction to recognize prescription drugs as the major health care expense which they are.

We don't agree with those who say that few seniors will benefit from this legislation. Approximately 20 percent of Medicare recipients will collect benefits from the Act when all phases are implemented. We feel it is important to stress the insurance aspect of Medicare. Catastrophic coverage, by definition, is designed to help the relatively small number of individuals who will experience catastrophic medical expenses. The basic concept of insurance is to spread the risk over a large group, making it affordable for everyone. Catastrophic protection is like other insurance—most people hope they will never have to "benefit" from their auto or fire insurance policies.

The Act provides increased respite care, home health aide care, and, perhaps most importantly, provides for a decent standard of living for spouses of institutionalized seniors. This spousal impoverishment provision will ease the worries of many minority seniors.

We strongly support a comprehensive long-term care bill while recognizing that it is a very complicated and expensive proposition which will require some time to develop and implement. We have lobbied for long-term care legislation in the past and will do so until this very important need is met.

Our biggest concern with the Catastrophic Act is the way it is financed. We believe the financing is flawed and unfair. We do not object to "progressive" means of financing these benefits, under which wealthy individuals are required to pay more than the poor. Nor do we object to a financing mechanism which provides a subsidy to lower income persons. But we do object to the basic principles underlying the

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mechanism which was chosen to finance the benefits—namely, that the benefits would have to be paid for entirely by the elderly.

This principle was incorporated into the new law because President Reagan insisted at the outset that any new Medicare benefits would have to be paid for by senior citizens themselves. Many members of Congress went along with this principle because, as a result of the huge federal budget deficits that have been run up under the Reagan Administration, there simply wasn't any money in the Federal Treasury to pay for new benefits.

Requiring the elderly to pay for the entire cost of the catastrophic benefits is wrong for several reasons. Most importantly, it violates the basic social insurance principles which have formed the basis for Social Security and Medicare. This could establish a dangerous precedent for undermining these programs in the future. Furthermore, the net result is that middle and upper income seniors have to shoulder the entire burden of paying for the subsidies for the lower-income elderly. This burden should properly be shared by all of society, not just the more fortunate segment of the elderly.

We do not support repeal of this legislation. Given that the legislation includes an important expansion of benefits, we do not, so to speak, want to throw the baby out with the bath water. We do strongly urge Congress to find other ways of funding the Catastrophic Act, thus removing the additional financial burden from the backs of the elderly. This should be done by substituting other revenues based more directly on traditional social insurance financing principles.

Again, thank you for the opportunity to testify today.

Senator HARKIN. Thank you very much. Ms. Henderson, you talked about people in the community who would not see to their own physical health for fear of not having enough money to pay for their spouse's nursing home care. Do you think senior citizens in Iowa are learning about the spousal impoverishment feature of the Catastrophic Act in a timely fashion so they will feel safer about spending money, and caring for their own needs?

Ms. HENDERSON. In our area, yes. Just recently we had a forum to educate them in our Area Agency on Aging. We're spending a great deal of time out in the counties stressing that, and also through newspapers and our newsletters we are trying to get the word out so that more people will be educated to that. The spousal impoverishment feature is already enacted this year——

Senator HARKIN. That's right. And it allows a spouse to keep up to $800 a month in income, $12,000 in assets, plus the home.

Ms. HENDERSON. Up to $60,000, depending on your income, that they could retain——

Senator HARKIN. That they could retain, that's right. Before that, we had no coverage at all for spousal impoverishment.

Ms. HENDERSON. No; they counted the couple's joint income, and they had to spend up to $1,800 in the State of Iowa—whichever spouse is in the nursing home, they had to spend $1,800 out of his or her money.

Senator HARKIN. Do you know if senior citizens in Iowa are well informed about the Catastrophic Care Act in general? For example, my office receives calls about people paying supplemental premiums, when after discussion with them, it's quite clear that they are part of the 60 percent who do not have to pay the supplemental premium. I'm concerned about a lot of misinformation getting out.

Ms. HENDERSON. I don't think there's been that much publicity on the low income. There should, and we're addressing that now. You're talking about, Senator Harkin, the low income that don't have to pay that premium any longer? We're getting that information out, but sometimes you almost have to go head-to-head.

Senator HARKIN. I have not seen the tape.

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Ms. HENDERSON. We have it. In fact, I have it on my TV at home. I haven't seen it yet.

Senator HARKIN. I would hope that we would get that video out to all senior meal sites, senior centers, things like that, so that people can see it.

Ms. HENDERSON. We have directed presentations to approximately 650 people in our seven-county area this last month. I also wanted to just make one statement about cost because I didn't have anything in my presentation, and it appears that that's something that you're looking for. And this is my personal opinion, but basically with 11 years of working with senior citizens out there and seeing what's happening to them, I just feel that this Government, our Government, our Senators, legislators, need to be working on some kind of a comprehensive health care plan that will not only cover senior citizens but will start from infancy through death and include long-term care. I would encourage financing through the Government, but not only the Government. Let the people in the private sector help, I don't mind helping to pay for that, I can see what happens. It's not going to be easy, and I don't have all of the answers, but I think that's something to look at. [Applause.]

Senator HARKIN. Mr. Conger, I was recently visited by the Retired Federal Employees Association representative in Washington who expressed the same concern as you about the Catastrophic Care Act, and specifically about the supplemental premium. I understand that there's an adjustment made in the law for Federal retirees for the purposes of calculating the supplemental premium. That adjustment was made in order to lessen the impact on Federal retirees whose pensions I mentioned in my opening statement are taxable, whereas most Social Security benefits are not subject to taxation. Have you reviewed these adjustments that were included in the law? Do you feel that they are sufficient to equalize the situation of Federal retirees versus the private sector?

Mr. CONGER. That was a statement that I had made. In other words, in my own case, approximately $4 a month, or $48 for the year, they take off so that I can pay $225, plus $225 for my wife if I pay the same next year. So it doesn't seem to me like it's adjusted quite right.

Senator HARKIN. So the adjustment is not quite right? I think that's something that we should probably look at, then. I wanted to also note that the Office of Personnel Management, which administers the Federal employee health benefits plan, is to issue a report on how the plan can be made more equitable as a result of the changes made by the Catastrophic Care Act. We'll look at that closely. Again, as I said, you know Senator Bentsen said he would have hearings this year, and he specifically mentioned inequities with regard to Federal retirees, so I'm sure your association will be testifying.

Mr. CONGER. And someone said that the cap situation might help.

Senator HARKIN. Mr. Jackson, you made a very good point that I think is too often forgotten, and that is that Medicare catastrophic coverage is an insurance program. And with most insurance programs, you hope you'll never have to use them, but you're glad you've got it once you need it. You also mentioned in your remarks

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the welcome expansion of prescription drug benefits and the protection against spousal impoverishment. Among the seniors you work with through your outreach program, do you get a sense that your people are informed about the catastrophic coverage benefits? And are they pleased with it, or what concerns do they have?

Mr. JACKSON. No. 1. They're not informed. That's one of the jobs that we will be doing over the period of the next year, I would say. And if they're not informed, they don't know about the benefits. So we will utilize a video and other things and go to the senior homes—go to the homes, and go to the places where they congregate in smaller groups and inform them of what is available and see where we go from there, sir.

Senator HARKIN. You talked about the long-term care—all of you mentioned long-term care, one way or the other, and Ms. Henderson spoke about it at length. Among the seniors that you deal with, Mr. Jackson, when they talk about long-term care, are they more interested in nursing home care, or would they be more interested in long-term care that would be provided them in their own homes?

Mr. JACKSON. The ones that I work with, and I'm not only talking about minorities now—in this area I've worked with both; I happen to have been the advisory chairman of the area agency for about 2½ years—I would say the long-term care that most of them are speaking of is more like home health care, being able to stay in their own home. Most of them have their homes, but more than likely the spouse is gone, and they need a certain amount of care, and they can't be provided—a good portion of it can be provided with home health care. That's my opinion, and that's what I'm finding.

Senator HARKIN. OK. Again, thank you, all three of you, for being here. Some of you came a long distance.

STATEMENT OF JANE ROBERTS, VICE CHAIR, STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Senator HARKIN. Our final panel focuses on the issues of long-term care, a critically important health care issue here in Iowa and across the Nation. On this panel we have Jane Roberts, vice chair of the Iowa State Legislative Committee of the American Association for Retired Persons; Mr. Ronald Pollack, the executive director of the Villers Foundation; and Ms. Loretta Tarbox, who chairs the Long-Term Care Committee of my Iowa Nurses Advisory Committee. I want to welcome you all. I would, again, appreciate it, since our time is running out, if you could please summarize your statements for us. First, I'd recognize Dr. Jane Roberts. Again, welcome to the subcommittee.

Mrs. ROBERTS. Thank you, Mr. Harkin. My name is A. Jane Roberts. I'm the vice chairman of the AARP Legislative Committee for the American Association of Retired Persons. I am pleased to be here on the panel today to talk about the Medicare Catastrophic Coverage Act enacted into law last July.

During the nearly 2 years that this legislation was being developed by Congress, AARP played a very active role in expanding the benefits package so that it would be meaningful to older and dis-

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abled Americans. We also worked to broaden the financing so that it would not rely exclusively on Medicare beneficiaries.

On the benefits side we were successful. Strong lobbying by a number of aging groups including AARP, and conscientious work by Democratic and Republican Members of Congress, resulted in the generous package of benefits which were described earlier today. These benefits will be used by 22 percent, or 1 out of every 4 Medicare beneficiaries sitting here today. Over the course of our lifetime, the chance of us using these benefits is 75 to 85 percent.

Broadening the financing package faced major obstacles. The Catastrophic Coverage Act was developed during a period of intense concern over the Federal deficit. When President Reagan proposed the expansion of Medicare, he set the terms for his support: Any expansion of Medicare could not increase the Federal deficit and must be financed exclusively by Medicare enrollees.

AARP persisted and lobbied for additional financing services, the inclusion of all State and local workers in Medicare, and an increased tobacco tax, ultimately without success. We were, however, successful in persuading Congress to change the financing so that it would be fair for middle-aged beneficiaries.

In the end we were faced with hard choices, accepting a financing plan which we did not like, or passing benefits like prescription drug coverage and protection against spousal impoverishment benefits, which means the difference between independence and dignity or poverty for many older Americans. Would we pass up the most significant improvement in Medicare? Would we defeat the purpose of added protection and ultimately endanger chances for long-term care by insisting that the bill be financed by revenue sources which more appropriately should be spent for long-term care? Our answer after much thought and debate was, no.

At its March meeting, the AARP board looked again at the association's position and reaffirmed AARP's position. The board's position is that we would continue to support the important benefits provided by this law and, therefore, oppose repeal or delay in its implementation. AARP did not propose the act's financing method and does not believe it is the best approach. We would remain open to new proposals for funding the catastrophic program and will evaluate them in light of their equity and potential for support.

It is now time to look ahead toward the establishment of a comprehensive long-term care program. The Medicare Catastrophic Coverage Act moves us in that direction with the establishment of two long-term care provisions.

I doubt if there's a person inside this room who doesn't know someone who is now providing long-term care in their home to an elderly spouse or relative. The burdens of providing this type of care are immense, and until now there has been little in the way of assistance.

Senator HARKIN. Summarize, if you can.

Mrs. ROBERTS. I think we're all aware of the benefits for the need of long-term care and also the need for respite care, and we must continue to build upon these. Long-term care is needed by persons of all ages, not just older persons. Seven million American households have a child or an adult American who's chronically ill or disabled. Millions of chronically ill children and adults who need

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long-term care are outside of the Medicare/Social Security disability system and are not covered under private insurance.

The current Federal long-term care program, Medicaid, is inadequate to cover this for several reasons: It provides only limited home care; the degree of care varies from State to State; and because of the stigma as a welfare program, it often robs families of their dignity and independence.

The question before us now is how to spread the burden on long-term care, both the services and the costs, around to all. The answer is the social insurance program rather than a welfare program. AARP's proposal for long-term health care encompasses a number of issues and concerns. All Americans, regardless of age, should be eligible for the long-term care program. The services offered by a nationwide long-term care program should be inclusive. Nursing home care, day-care, in-home care, all constitute particular valuable resources to severely disabled Americans who require assistance.

Identifying realistic and adequate funding sources for the comprehensive long term area is one of the toughest issues which the Congress and advocates can address. AARP advocates a social insurance approach to funding. Our attention is focused on beneficiary copayments, deductibles and premiums, payroll, estate and gift taxes, and maintenance of Government spending on long term programs, such as Medicaid.

It's important to recognize that just because the cost of a program is not registered in the Federal budget, they may nonetheless represent real costs to society. It is critical to recognize that the costs of long-term care are now borne by society, but borne in a very uneven way. A publicly provided program would help to spread those costs in a more affordable manner across the population, while assuring all of our citizens access to the care.

The association looks forward to working with Congress to find realistic solutions to long-term care financing problems. We believe Americans are ready to face this challenge to protect current and future generations of families from the devastating costs of illnesses that require long-term care.

Senator HARKIN. Thank you very much.

[The statement follows:]

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STATEMENT OF JANE ROBERTS

Thank you Mr. Chairman. My name is Jane Roberts and I am the Vice Chair of the Iowa State Legislative Committee for the American Association of Retired Persons. I am pleased to join you today to talk about the Medicare Catastrophic Coverage Act enacted into law last July.

During the nearly two years that this legislation was being developed by Congress, AARP played a very active role in expanding the benefits package so that it would be meaningful to older and disabled Americans. We also worked to broaden the financing so that it would not rely exclusively on Medicare beneficiaries.

On the benefits side we were successful. Strong lobbying by a number of aging groups - including AARP - and conscientious work by Democratic and Republican members of Congress resulted in the generous package of benefits we have heard described today. These benefits will used by 22% of all Medicare beneficiaries - that's one out of every four beneficiaries in this room. Over the course of our lifetime the chances of us using these benefits is expected to increase to 75%-85%.

There were obstacles, however, to broadening the financing package. The Medicare Catastrophic Coverage Act was proposed during a period of intense concern over the federal budget deficit. When President Reagan first proposed the expansion of Medicare he set the terms for his support - those terms were that it could not increase the budget deficit and it would be financed completely by Medicare enrollees.

AARP proposed and lobbied for additional financing sources - the inlusion of all state and local workers in Medicare and an increased tobacco tax - ultimately without success. We were successful however, in persuading Congress to change the

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financing so that it would be fairer for middle-income Medicare beneficiaries.

In the end, were were faced with hard choices - accepting a financing plan which we did not like or passing up important benefits like prescription drug coverage and protection against spousal impoverishment - benefits which mean the difference between independence and dignity or poverty for many older Americans. Would we pass up the most significant improvement in Medicare? Defeat the purpose of added protection and ultimately endanger chances for long-term care by insisting that the new Medicare benefits be financed by revenue sources which more appropriately should be spent on long-term care? AARP's answer - after much thought and debate was no.

At its March meeting, the AARP Board reviewed the Association's stand and re-affirmed the Association's position. The Board stated that AARP remains committed to the benefit package provided by the Medicare Catastrophic Coverage Act and therefore opposes repeal or delay. The Association did not propose the financing method and still does not like it. AARP remains opens to new financing proposals and will carefully consider them in light of their equity and feasibility.

It is now time for all of us to look forward towards the establishment of a comprehensive long-term care program. the Medicare Catastrophic Coverage Act moves us in that direction with the establishment of two long-term care provisions.

I doubt if there is a person in this room who doesn't know of someone who is providing long-term care in their home to an elderly spouse or relative. The burdens of providing this type of care are immense and until now there has been little in the way of assistance. The Catastrophic Coverage Act creates a new in-home respite care benefit of eighty hours. This means that those who care for the frail, homebound elderly will now get the

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help they need in order to be able to get out of their homes for a few hours a week to go to the doctor, get groceries or simply go for a walk. Eighty hours is modest, but the establishment of this benefit signals Congress' recognition of the extraordinary contributions of thousands of Iowans and others who take on the burdens of providing long-term care in their home.

The other benefit - financial protection for the spouse of Medicaid nursing home residents will eliminate the tragedy of impoverishment we witness time and again when couples find they must deplete their savings or divorce in order to secure Medicaid coverage of nursing home care. One of the most striking examples of this cruel situation occurred right here in Des Moines. Mary Hill, a Des Moines resident, was forced to divorce her husband of many years so that he could qualify for assistance without leaving her penniless. The income and asset protection provided by the Catastrophic Coverage Act are particularly important for couples, like the Hills, who carefully planned for financial security in their retirement but an unforeseen illness threatens their life savings.

We must continue now to build upon these long-term care benefits. Long-term care is needed by Americans of all ages - not just older persons. Seven million American households today have a child or adult member who is chronically ill or disabled. Millions of these are out of the realm of the Medicare/OASDI system and are not covered under private insurance.

The need for a long-term care system also extends beyond those who need the care to the family and friends who provide personal care and financial support. Family members are the cornerstone of the long-term care delivery system. They provide the bulk of daily care on an unpaid basis. Only 5% of elderly rely solely on paid providers for their care.

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The need for long-term care inevitably leads to an unmanageable financial burden because the cost of care is often enormous. The average cost of one year in a nursing home is $25,000. Since few people can afford this expense, many end up on Medicaid after a financial catastrophe has occurred. While Medicaid picks up a substantial share of nursing home costs, more than half of these costs are paid by residents and their families.

The only current federal long-term care program - Medicaid - is inadequate for several reasons: it provides only limited homecare; the degree of coverage varies from state to state and because of its stigma as a welfare program is often robs families of their dignity and independence. The question before us now is how to spread the burden - of services and costs - around to all. The answer is a social insurance program rather than a welfare approach.

AARP's proposals for long-term health care encompass a number of issues and concerns. All Americans, regardless of age should be eligible for long-term care programs. The services offered by a nationwide long-term care program should be inclusive. Nursing home care, day care and in-home care all constitute particular and valuable resources to severely-disabled Americans who require assistance.

Identifying realistic and adequate funding sources for a comprehensive long-term care program is one of the toughest issues which the Congress and advocates of long-term care must address. AARP advocates a social insurance approach to funding. Our attention is focused on beneficiary copayments, deductibles and premiums, payroll, estate and gift taxes and maintenance of government spending on current long-term care programs such as Medicaid.

It is important to recognize that just because the costs of a program do not register in the federal budget, they may

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nonetheless represent real costs to society. It is critical to recognize that the costs of long-term care are now borne by society but borne in a very uneven way way. A publicly provided program would help to spread those costs in a more affordable manner across the population, while assuring all our citizens access to care.

AARP looks forward to working with Congress to find realistice solutions to the long-term care financing problem. We belive Americans are ready to face this challenge to protect current and future generations of families from the devastating costs of illnesses that require long-term care.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, VILLERS FOUNDATION

Senator HARKIN. Ronald Pollack, executive director of the Villers Foundation. And, again, my thanks to the Villers Foundation for all that it is doing to promote the concept of long-term health care, and for the Villers Foundation getting information out to the elderly all across the country as to what's involved in this process.

Mr. POLLACK. Thank you, Senator Harkin. I'm delighted to follow you to Iowa, particularly since I know that America seniors, indeed, Iowa seniors, have no greater champion than Tom Harkin. [Applause.]

Mr. POLLACK. I'm delighted to be here. I'm going to focus a little bit on what's not in this legislation, so that we can take a look at what we need to do in the future. And particularly, the charge that your staff has given me is to focus a little bit on long-term care because we know that long-term care, essentially, is not provided for in the catastrophic legislation or indeed in Medicare.

Generally by and large, the American population until fairly recently was unaware that long-term care was not covered by the Medicare Program. A few years ago the AARP undertook a survey of its own membership, and about three-quarters of the membership at that time indicated that they believe that Medicare covers long-term care. We know, of course, that is not true. We also know that there's very little private insurance that's available for long-term care. What exists is extraordinarily expensive, and it covers very little. And there have been very, very few policies that have been purchased in the private sector, so we do not get protection in the private sector at all for the vast preponderance of seniors in the United States. What does exist, however, is the Medicaid Program, and the Medicaid Program, essentially, has two flaws when it comes to long-term care: No. 1 it's deeply means tested, and what that means is only those people who are essentially destitute, who have lost the opportunity to have adequate income, who do not have adequate resources. It is only for those people who the Medic-

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aid Program provides any kind of coverage. And for those people who do receive coverage under the Medicaid Program, one of its most difficult features is essentially—the only kind of care you receive—is care in an institution, and most people—I'm sure this is true in Iowa, certainly throughout the United States—most people would like, if it is at all possible, to receive their long-term care in the home or in the community. And it's very difficult to receive that through the Medicaid Program.

We know that nursing home costs are skyrocketing; they have shot through the roof. The average cost of a nursing home care stay today is approximately $30,000 a year, and in many places around the country it far exceeds $30,000. Care in the home, depending upon what kind of care is needed, can also be extraordinarily expensive and people essentially just cannot afford that kind of care which is truly catastrophic.

Now, one of the things we've tried to do is we've tried to ascertain: What does the American public feel about long-term care? What do they want, and what would be their experience with respect to long-term care?

And if I may, I'd like to share with you some of the poll data that we've gathered first from the United States, and then what we've gathered specifically in Iowa. In the United States we undertook a poll that was supposed to be representative of the entire voting population, and what we did was we essentially asked people: "How many have already experienced a need for long-term care in their immediate family?" I say immediate family, I don't mean aunts and uncles, I mean immediate family: Parents, grandparents, children. And, "How many have experienced a need for long-term care among their best friends?" The answer, frankly, surprised us very greatly. Sixty-one percent of the American public has already experienced a need for long-term care in their immediate family or among their best friends. Of the remaining 39 percent, we asked those individuals: "Which of you expect to have a need for long-term care in your immediate family within the next 5 years?" Over one-half of the remaining 39 percent said that they expected to have a need for long-term care in their immediate family within the next 5 years. Now, if you aggregate those two groups together, the 61 percent that already have had such an experience and one-half of the remaining 39 percent, more than 4 out of 5 Americans have already experienced or are about to experience a need for long-term care among their closest loved ones. We asked people: "Do you think that this is an area for Government intervention?" Eighty-six percent of the American public has said that long-term care is an area where they believe Government intervention is necessary.

Now, we asked Democrats, we asked Republicans. We wanted to see whether it was a party phenomenon or something else. Ninety-two percent of those who identified themselves as Democrats said they thought this was an area for Government intervention. Eighty-two percent of those who identified themselves as Republicans said this was an area where they thought there should be Government intervention. Then we asked what I call the nonfree lunch crowd: "Are you willing to pay for it?" And we've had quite a bit of discussion here today about what people are willing to pay

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and what they're not willing to pay, so it's important to ask that question, because certainly that's an issue that would be uppermost in the minds of your colleagues as they consider legislation. Now, what we did with this is we didn't ask the question merely in the abstract. We tried to point out in advance, at the beginning, how much income did a person receive, and we then tried to calculate very quickly based on that income what additional taxes that they might have to pay for comprehensive long-term care policies. And what we did was we took—for those people at the lowest end of the income ladder, we presumed that they would have to pay an extra $10 a month, or $120 a year in taxes for such a comprehensive program. For those at the higher end, we presumed $60 a month or $720 a year in extra taxes for this comprehensive policy. It was on that basis that we asked the question, and by a margin of over 5 to 2, the American public responded that they were willing to pay extra taxes for long-term care.

Now, I hasten to add that the poll data reflects that this is not just an issue that impacts very seriously among American seniors. The popularity of long-term care as an important issue is of no lesser significance for younger generations than it is for those in older generations. And, indeed, the poll data shows that those in younger generations, like my age, were at least as interested, if not more interested, in having Government intervention and paying for that Government intervention for long-term care because long-term care impacts on their lives as well. So this is an extraordinarily high priority for the American public.

If I may, let me give you some of the Iowa polling data. We undertook a separate poll in Iowa, and I'm just going to give you some of the salient features of that. Over two-thirds of those polled in Iowa said they have already had some experience with long-term care in their families or close friends, slightly higher than the American average. More than 6 out of 10 expressed a willingness to pay additional taxes; again, we used the same kind of tax rate as we did in the national data. For long-term care for the elderly and the disabled, we broke down these questions for different age groups, and what we did was we asked each these age groups questions about priorities for Government spending, and we arbitrarily chose eight areas. The eight areas were: More money for the environment; more money to aid the homeless; more money for new transition programs for mothers and infants; more money for low and moderate income housing; loans and grants to college students; the space program; defense, and long-term care.

In each of those eight categories, we broke this down for age groups 18 to 39 age group, 40 to 59, and those age 60 and above. And for each of those age groups, long-term care came in No. 1 as their highest priority. And no single item came in as high as third in all age groups. Long-term care came in first with all age groups.

Senator HARKIN. Even the youngest group?

Mr. POLLACK. Even in the younger groups. Aid to the homeless came in No. 2, and college loans came in No. 3. We then asked questions of Democrats and Republicans in each of these areas, and we tried to find out what their ranking—we asked them whether they support increase in funding in each of these areas, or in the alternative, whether they would prefer to see a cut or a freeze in

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Government expenditures. With respect to the Democrats, there were five areas that received majority support for increasing; No. 1 on the list was long-term care. With respect to the Republicans, of the eight, only one received majority support, and that was long-term care. It, too, was listed No. 1 among the eight areas that we asked.

Finally, we wanted to ask questions about how politicians might be perceived if they made long-term care a priority for them, so we asked some negative questions and some positive questions as well, and I'll give you a few. We said: "If a candidate strongly supported long-term care, would you consider that candidate a big spender?" Nine percent said that they agreed he is a big spender; 79 percent disagreed; the other 12 percent didn't know.

We asked: "If such a person does support long-term care, does he pander to special interest groups like the elderly?" Thirty-three percent said "yes;" fifty-seven percent said "no." We asked: "Does he show compassion for your parents?" Seventy-eight percent said "yes;" sixteen percent said "no." And finally: "He shows the kind of leadership and vision that I like." Eighty-four percent said "yes," and 10 percent said "no." [Applause.]

Mr. POLLACK. Now, we know Senator Harkin has that compassion. It is clear from the data both around the United States, as well as in Iowa, long-term care is an exceedingly high priority. I'd be delighted to talk about how we fashioned such a program, but clearly that's the next task at hand. I thank you.

Senator HARKIN. Thank you very much. Extremely interesting. Thank you very much, Mr. Pollack.

STATEMENT OF LORETTA TARBOX, DIRECTOR OF NURSING, VILLA CENTER AND MEMBER, NURSES ADVISORY COMMITTEE

Senator HARKIN. Loretta Tarbox, welcome to the committee. You have been a very active member of my Nurses Advisory Committee for the last several years. I appreciate your involvement in that and thank you for coming.

Mrs. TARBOX. I feel honored to be invited to participate in this. The testimony that I presented to the Senator and his staff is especially representative, so I would like to digress from that with a few remarks that I've jotted down and the observations that I've made both in this session and prior to arriving here.

In the past many days we have heard an awful lot, especially in Iowa, from the families that decry the loss of opportunity for athletes to become professionals and the loss of income for the university. These same fans have not answered the question: "Doesn't the university have a right for those who represent them to be literate?" Will they spend taxpayers' money on that? How often do we have these same fans decry the fact that the frail elderly in our State have no opportunity to gain health care? But Congress has passed the catastrophic health bill, what more can we ask? Recently a writer in one of the local newspapers—and I cannot identify him—I simply do not remember who it was—said that the elderly do not have a right to health care. Now, I disagree with this philosophy entirely, and I believe in care for those who are elderly and frail, and I will work for monetary relief for some of their problems. I've done that up to this point by being on the funding task

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force and the first director of the home health care agency in our county, and I think our county is representative of our State. I was first director of our hospice agency, and I was on the task for now, trying to start a respite agency, and at this point we're struggling with that a little bit, primarily because of funding.

In my 40 years of nursing, I have been overwhelmed often as I remember that the patients when I was a student complained about $80 a day for a private room, $80 a day for a private nurse. Today no amount of money is going to buy a private nurse, and your average cost in the general hospital in rural Iowa is about $500 a day. When I think about the charges for health care, the premium costs of health care insurance, and the limitations of coverage, I am reminded of some of the experiences in which I have been involved recently, as I direct nursing care in the long-term facility. The catastrophic health care bill is great for those in need of skilled nursing or acute care, but what of those who are categorized as intermediate care recipients? As long as they have no more than a couple thousand dollars to their name, they can get the help; they have to reach that point of impoverishment. These are the recipients, not the spouse's, although spouse's suffer. In most proprietary insurance companies, the requisites preclude coverage where the need is first identifed. And by that I mean you have to be in a hospital for 3 days, you have to be sick for a given number of times, you have to have a certain diagnosis. I hope that when my mother goes to the hospital to have a cancerous growth removed from her face that she will be able to stay long enough to come out of the anesthetic. Therefore, impoverishment is the quickest way to get help, and that is a sad thing when we think about that. We must be to the state of poverty before someone is going to help us take care of our physical needs. In the past few days I visited a physician, and I asked: "How has the catastrophic health care bill helped your patients?" And I had an hour-long lecture, not too positive, not because it was a physician, but because of the limitations of the coverage. And they have to declare that these patients are in need of skilled care when, in fact, perhaps they could get along with lesser intense care if there were some way to cover the cost. I must add that they admitted that very few patients have that need, but they also say that we are, what is it, "A day late and a dollar short."

As I interviewed potential residents for the facilities for whom I work, I am very aware that they are anxious about the expenses, particularly if there's a spouse at home. And the conclusion I draw from this research and the experiences is that to qualify for assistance, and not for the average person in declining health and advancing age, but rather the victim of an exotic illness who have to be fiscally and physically poor. And at this point, I would like to point out that the things we've heard today have all been so true in my experiences, trying to assist these persons who are, in fact, not in need of the catastrophic health care coverage, but rather long-term coverage. In my facilities I have one patient that's 104; I have four who are becoming 100 years old this year. These people don't have families; they've outlived their families. They don't have the resources. Catastrophic health care does cover medicine, I think that's great. But what about the long-term care? Their medi-

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cines are not covered, and their medicine are no less voluminous than are the acute care patients. Thank you.

[The statement follows:]

STATEMENT OF LORETTA TARBOX

On July 1, 1988 President Reagan signed HR 2470, Catastrophic health insurance legislation into law (Public Law 100-360). Effective January 1, 1989 it provided allegedly unlimited hospital care to the nation's elderly. The new law caps medicares beneficiaries out-of-pocket cost for physician services in 1990 and provide for partial payment of prescription drug coverage starting in 1991. The benefit of skilled nursing care per illness has increased to 150 days per year. In 1990 beneficiaries will be eligible for 38 consecutive days of Home Health Care instead of current 14 to 21 days. Two new Medicare premium will be levied on beneficiaries to fund these new benefits. An additional $4 per month has been applied to all medicare beneficiaries in 1989 to be advanced to $10 per month by 1993. A cap on out-of-pocket annual beneficiary payments under this premium is set at $800 in 1989 and $1,050 in 1993.

Representative Henry Waxman (D-CA), Chairman of the Health Subcommittee of the House Energy and Commerce Committee, was also successful in incorporating two Medicaid initiatives in the catastrophic bill. The first is a spousal impoverishment protection provision which will protect the married spouse of a nursing home resident from becoming impoverished before Medicaid funding will be available. The spouse residing in the couple's home may now keep joint income up to the level of 122 percent of the poverty line for such a couple. In 1992, the amount rises to 150 percent of the poverty line. The second provision will require states to provide women with incomes below the poverty line full pregnancy-related Medicaid benefits. Children under the age of one year will also be eligible for such benefits. A phase-in of this provision will be complete in 1990.

It is a fact that the elderly spent $1,894 per capita for health care in 1988, 2½ times what they spent eight years earlier. They pay 18.1 percent of their income today as opposed to 12 percent in 1980.

Out-of-pocket expense is any health care cost including direct payment for services, coinsurance and deductibles, private insurance premiums and Medicare Part B and Part A premiums except those paid by Medicaid.

American elderly have lost billions in purchasing power since 1980. With respect to health care, American's elderly would be spending $21.9 billion less ($718 per person) in 1988 if they were spending the same percentages as they were according to Rep. Edward Roybal of California. During these same eight years, annual income for the elderly rose 7.1 percent while their health care expenses rose 12 percent. The Catastrophic Health Care bill will not compensate for these losses but may assist in limiting further such devastating losses by the provisions to cap out-of-pocket expense.

Medicare has been the sacrificial lamb of the budget conscious in the government.

Catastrophic legislation addressed important problems of America's elderly. It failed significantly to address what the elderly perceive to be their greatest problem—the cost of Long Term Care.

The Catastrophic insurance law has made it easier for patients to get Medicare coverage for nursing home stays. It eliminates the requirement that nursing home admission must be preceded by a three day hospitalization. The law reduced beneficiaries share of the bill and increased the number of days that residents will be eligible for coverage.

The changes in the law have prompted some nursing homes to have increasing number of their beds certified for Medicare.

To enlarge upon above mentioned benefits may I compare previous with current.

Previous	Current
3 day hospitalization prior to admit to Skilled Care	3 day hospitalization not necessary.
110 days coverage	Extends coverage to 150 days per episode of illness.
Medicare covered patients were required to contribute $65/day after first 20 days. Medicare paid 100 percent first 20 days—often paying full cost. $65/day very often rapidly exhausted personal resources causing patient to rely on Medicaid.	Recipients pay $25.50 first eight days. Medicare pays 100 percent thereafter.
Hospice Care limited to 210 days	Hospice care is reimbursable beyond 210 days if patient is recertified or terminal.

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Previous	Current
Home Health Care—5 days/week for 2 or 3 weeks	Home Health Care—is now 38 days of any given period.
Respite Care	Respite care of 80 hr/Year for chronic dependent individual who needs care with 2 areas of ADLs, if eligibility requirement is met.
Spouse Impoverishment	Spouse impoverishment—Institutionalized resident. Spouse must be allowed sufficient funding to meet 122 percent of poverty level.

New legislation that represents the most significant expansion in Medicare benefits in years ignores the largest portion of out-of-pocket Medicaid cost borne by the elderly. The bill designed to protect the elderly from Catastrophic illness costs will do next to nothing for the real Catastrophic issue—Long Term Care.

Women are particularly disadvantaged by the bills limitations. Three-fourths of all elderly in nursing homes are female—nearly 1 million. It is estimated that another 5 million also need Long Term Care for a chronic illness or disability.

Medicare beneficiaries who currently pay nearly $300 per year in premiums plus large deductibles and 20 percent of each doctor bill spends approximately the same portion of their income as prior to the passage of the Medicare Act of 1964 normally 15 percent. Citizens with annual incomes between $5,300 and $8,000 are driven into poverty by health care expenses.

There is a positive side of this bill in that it sets caps tied to inflation of $1,800 on out-of-pocket expenses. It also begins to cover services other than acute care. It also expands Home Health Care and covers for first time 80 percent of outpatient prescription drug costs after a deductible of over $500.

[From Elder Echoes, Iowa Department of Elder Affairs]

Catastrophic Health Care Now in Effect

The United States Congress has passed new legislation that is called the Medicare Catastrophic Coverage Act of 1988. The title is deceptive because the catastrophic costs of long-term custodial care provided either in an individual's home or in a nursing facility is not covered. Doctors' fees exceeding Medicare's "approved" amounts will also not be covered under this new legislation. A few new benefits, such as respite care and spousal impoverishment aid, have been added. The bulk of the coverage is already provided for by the good private insurance Medicare supplement plans available. It is important to remember that even with the new changes, supplemental insurance is still necessary to cover the remaining deductibles and co-payments. The senior citizens who will be assisted by this legislation are the 20 percent who currently have no Medicare supplements and senior citizens with incomes below the poverty line. Their Medicare premium deductibles and co-insurance will be paid by state government. The senior citizens who will be hurt are those with sufficient income to pay federal income tax because this law requires them to pay a Medicare Supplemental Premium based on their federal income tax liability.

Benefits affecting Part A coverage for in-patient hospital care, skilled nursing home care and hospice care take effect on January 1, 1989. Part B benefits affecting doctors' fees, out-patient care, home health care and the new respite care benefit are effective on January 1, 1990 and the new out-patient prescription drug benefit begins on January 1, 1991.

Part A benefits.—Medicare will cover in-patient hospital costs except for a deductible for the first hospital stay per calendar year. (The 1989 deductible will be $564.) Medicare previously has provided full coverage only for the first 60 days per benefit period, and then required large co-payments after 60 days. Persons with a good Medicare supplement already have this coverage for co-payment and will receive no new benefit.

Nursing home coverage is still restricted to daily skilled care. Most people in nursing homes receive intermediate or custodial care and will not be covered by this catastrophic health care legislation. One improvement, however, is the elimination of the current rule requiring a hospital stay of at least 3 days prior to entering a skilled nursing facility. Senior citizens will pay a daily co-payment ($20.50 for 1989) for the first 8 days of covered care. Medicare will then pay up to 150 days per calendar year, but only as long as the patient received daily skilled care.

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Hospice care covers persons with a terminal illness or disease, who are not expected to live longer than 6 months. Medicare currently pays for up to 210 days of hospice care. In 1989 Medicare will pay an unspecified number of days as long as the doctor recertifies that the patient is still terminally ill.

Part B benefits.—Catastrophic care benefits for Part B will not begin until January 1, 1990. As previously stated, doctors' fees exceeding Medicare's approved amounts are not covered. After a $75 yearly deductible, Medicare currently pays 80 percent of what is approved. Supplemental insurance pays the remaining 20 percent approved amount. In 1990, Medicare will cover the 20 percent approved amount if it exceeds $1,370. Also counted toward the $1,370 limit are the $75 deductible and the Part B 3 pint blood deductible. This means supplemental insurance will pay the 20 percent co-payment as usual until it reaches $1,370 during 1990; Medicare will then cover all approved amounts above $1,370 for the rest of the year. Persons with good supplemental insurance will receive no new benefits with this provision.

Part-time skilled home health services are currently covered for 5 days a week for 2 to 3 weeks. In 1990, this will be expanded to 38 consecutive days. This covers only skilled nursing care, not homemaker or custodial services.

Beginning in 1990, women age 65 will have Medicare coverage for a mammography screening every other year.

A new respite care benefit will begin in 1990 for some chronically dependent persons. A person must live with a voluntary caregiver and be dependent on that caregiver for help with at least two activities of daily living such as bathing, dressing or eating. To qualify, a person must also meet the $1,370 Part B cap previously discussed or the $600 prescription deductible discussed in the next paragraph. Persons meeting all these requirements will receive up to 80 hours per year of respite care in the home to allow the normal caregiver time to get away for a vacation or rest. This respite care could include a homemaker, home health aide, personal care reviews or nursing care.

IN 1991, prescription drugs will be covered by Medicare. The deductible in 1991 will be $600, $652 in 1992, and somewhat higher in1993. Medicare will pay 50 percent of the costs exceeding the deductible in1991, 60 percent in 1992 and 80 percent in 1993 and thereafter.

CHANGING COSTS

The deductibles, co-insurance and premiums for these benefits will increase in future years.

The Medicare premium has always been the same for all senior citizens, regardless of income. This will change January 1989. A portion of the Medicare premium will now be determined by a person's federal income tax liability.

All seniors will see the Part B premium ($24.80 monthly now) increase by $4 per month effective January, 1989 to pay for catastrophic care. Senior citizens paying at least $150 in federal income tax will be charged a supplemental premium of $22.50 for each $150 of federal income tax liability. For couples, both husband and wife will each pay this premium. This premium will be $27.14 in 1990 and $30.17 in 1991. The maximum premium per person per year will be $800 in 1989, $850 in 1990 and $900 in 1991. The premium will be paid when the person or couple pay their federal income tax.

Spousal impoverishment is the situation where the spouse at home is allowed very limited income and resources when the other spouse is in a nursing facility receiving Medicaid. In some cases, the spouse at home is only allowed $354 per month to meet all living expenses. Effective September 30, 1989, the spouse at home will be allowed to keep 122 percent of the poverty income for a couple (currently $786 per month).

Some senior citizens facing a nursing home stay try to "give away" or transfer their assets to someone instead of using them to pay their nursing home costs. States currently have differing rules and time tables regarding these transfers. One or after July 1, 1988, transfers made within the 30 months before applying for Medicaid will delay Medicaid coverage for the number of months necessary to spend the transferred value on nursing home care.

Senator HARKIN. Thank you very much for that fine testimony, Loretta. I'm glad that you did focus on long-term care. We do have to do some things. We are going to have some hearings on the catastrophic care bill, but one thing I hear about more than anything else—and I go around Iowa and stop at congregate meal sites—the

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thing I hear about more than anything else is long-term care. Everyone is probably going to need some kind of long-term care at some point in their lives.

Mrs. TARBOX. Very true. And sometimes that time is now, but they are not of sufficient—seriously ill in order to qualify for the benefits of the catastrophic bill.

Senator HARKIN. I also want to point out one thing: I chair the Handicapped Subcommittee in the Senate, and one thing about long-term care that is true is that it is not just an elderly issue; it is an issue for all ranges of age in our society. How about a family with a disabled child?

Mrs. TARBOX. The subcommittee on the Nurses' Advisory Committee is honing in on that very thing, not speaking toward the elderly needs specifically, but rather respirator-dependent children, things in a home care situation, those persons who are handicapped need mechanical means to function.

Senator HARKIN. And many times those are young parents who are just starting out. They don't have financial resources, and with the burdens of caring for a disabled child, they are just overwhelmed. There's just nothing they can do about it; and they just can't cope with it. You see a lot of strife in families. A young family taking care of a disabled child, sometimes means that they are never able to go out to dinner, they can't take a vacation, they can't get away because there is no one qualified to come in and take care of a respirator-dependent child. This is something that is much broader based, and for all of you that are in this room, I want you to know, though, that I have a lot of allies that aren't senior citizens involved in this battle for long-term care. There are different aspects of long-term care, but it's a complicated issue. People talk about the need for respite care, in-home care and nursing home care. Home care can be very expensive. How do you see us starting down the path on long-term care? Any one starting point that you think we could start from? Mr. Pollack?

Mr. POLLACK. I think that the highest priority right now is for us to do something in home-based and community-based care. Obviously, we want to have a comprehensive system, we want a system that will cover institutional care as well as home-based and community-based care. Really if we had to pick a place to start, that would be the place where I think would be wisest to start, and there are several reasons for it: No. 1, it's the place where most people want care. If they can get care in the home and in the community, it's far more preferable than it is in an institution. It isn't as dehumanizing. People like to be within the walls that they're used to, they like to be in a community with friends. So there's no question, a matter of preference, the first priority would be home-based and community-based care. Second, one of the problems that we have is we don't really have an intrastructure right now for home-based and community-based care. What I mean by that—and there are many communities that have no home-based and community-based services that are available. If we provide a decent system of home-based and community-based care, we could establish that intrastructure, and we could think carefully about quality care in the home and in the community. I think that would be an extraordinarily good place to start. There's a third reason, and

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that's probably a practical consideration, and that is the cost associated in establishing an impressive community-based home-based service program is far less costly than it is for providing an impressive institutional care program. And given that we are dealing with the reality of a tight fiscal situation in Washington, starting with home-based and community-based services would be an excellent place to start. I think that's why Congressman Pepper decided to start in that area, and I think that's a good priority.

Mrs. ROBERTS. We will also concur with the county importance of community-based home services, and in Iowa, the Iowa State AARP Legislative Committee, along with other agencies, are supporting the development of coordinating a community-based service, which was referred to, in Linn County and on a pilot basis in Cerro Gordo County. And we want to see our Iowa Legislature continue to fund this approach so that every county in Iowa has a coordinated basis for this service.

Mrs. TARBOX. I think it absolutely should start in the home, as this gentleman said, this is where they want to be, this is where they're going to be the best off. And the time will come, certainly—almost certainly—that they will have to be institutionalized. But as long as they can stay in their own home, they're general well-being is so much better. And eventually they'll get to us, but delay it as long as we can.

Senator HARKIN. How about in the audience? As a starting point for long-term care, how many agree that we had ought to look at home health care?

[The audience raised their hands.]

Senator HARKIN. That seems to be pretty universal. Are there any bills that you know of that are pending right now that are looking at home health care?

Mrs. ROBERTS. Senator, I just received an alert to contact Grassley about laws of pending legislation they're going to be considering during the end of April to broaden Medicaid because, as we know, Medicaid is very biased toward institutionalized care. And if we could get some legislation that focused Medicaid on the greater use of community-based services and home-based services, I think——

Mr. POLLACK. Last week Senator Rockefeller introduced a bill, cosponsored by colleagues on the Finance Committee, that would broaden the Medicaid program to provide home-based and community-based care. Now, I don't mean to suggest that that is—that's what I'm talking about ultimately; I think it's a very important piece of legislation. However, what I'm talking about is trying to provide home-based and community-based care for people irrespective of income and resources and our social insurance principles. Until we get such a proposal like Mr. Pepper offered last year, or some modification of it, Mr. Rockefeller has introduced a bill that would expand the Medicaid program so that we don't have to jump through a number of hoops to get home-based and community-based services.

Senator HARKIN. Time has run me by. I want to recap. The panel can sit there, if you want. I just wanted to recap a little about what we've heard this morning.

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much. But the way I look at it is anybody that has a taxable income of $1,000 is going to pay that $22.50. Now that's a taxable income I'm talking about, they'll pay that $22.50, and he'll pay that on up to—if it's a married couple, they'll pay that on up to where they make $52,250, but at that point it's cut off. As far as I'm concerned—I don't make anywhere near $52,000, but I make enough that I'm going to have to pay that surtax on my total income, my total taxable income, and then they cut it off for the millionaire that's making $1 million a year at that $52,000. If they're going to have it, let's go right on up with it. These guys make $5 million a year. If he's making $5 or $10 million, he's paying a surtax on less than 1 percent of his income, and I'm paying it on every dime of taxable income that I make. So if I have to pay it on every dime of taxable income that I make, make him pay it on every dime of taxable income that he has.

Senator HARKIN. Well, it is true. It is true that right now in America the wealthy pay less of their income as taxes. That is the history of this country, that's for sure.

MEMBER OF AUDIENCE. I'd just like to clarify this: You mentioned about the deductible previously for inpatient care for 60 days, and really that 60-day extended care that we had for long-term illness was usually adequate. And then you mentioned about fire insurance and car insurance. That's our choice, we know we have uninsured motorists out there, but this catastrophic is not our choice. How about giving us a choice? I have one thing that disturbs me. In the August issue of Newsweek, we have the article: "Big Gray Money Machine," it refers to AARP as a tax-free empire. Why do they get by without paying tax on their insurance premiums that they collect? They say it's a right. As far as I'm concerned if it's income, it should be taxable. Then I have my question: Do you consider Alzheimer's a catastrophic illness? If so, where in the catastrophic bill do you see that an Alzheimer patient will get any help whatsoever?

Senator HARKIN. No; I consider Alzheimer's a long-term care problem.

MEMBER OF AUDIENCE. But where do you see that they will get any help in this catastrophic bill?

Senator HARKIN. They don't. That's why, for the Alzheimer's patients, it doesn't answer their needs at all.

MEMBER OF AUDIENCE. It's a catastrophic illness, as far as I'm concerned.

Senator HARKIN. That's one great big gap in the bill.

MEMBER OF AUDIENCE. I'm interested in the long-term care, very definitely. But before we get that, we need some home health aides and some good ones. And that would take some help from the Federal Government for their training.

Senator HARKIN. I feel that too. And I'm going to have to call it off. We'll do one more. This guy back up here has been trying to get my attention.

MEMBER OF AUDIENCE. I've heard it mentioned several times this morning, and I attended a meeting last Thursday, and people say unlimited hospital days. There are some cases where hospitalization is limited, for example, mental illness. I think it's 180 days for a lifetime. How about those? Don't those people count?

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hands. How many people would be opposed to paying for catastrophic through general revenues?

Now, I detect that most people here—now, some did not raise their hands, but most who did, said that they would be in favor of paying for a part of it through increased general revenues.

MEMBER OF AUDIENCE. Take all of the trust fund out the Federal budget, then tighten the screws down.

Senator HARKIN. Again, I'm trying to see how you feel about how it ought to be financed. I would say if I talked to at least 1,000 people, I might get at least 999 different ways. I'm trying to get a concept of how you feel we ought to be—how many would be willing to pay something themselves, say, just one part? Say, just the flat premium alone, but nothing else? How many would be willing to do that? Just a flat $4 a month? I just wanted to get that sense.

As this is a regular hearing by the Senate subcommittee, it's very difficult for me to call upon people in the audience. I have a little bit of time left, about 10 minutes, that I would be willing to entertain a comment or a question. I'm sorry I can't call on everyone; this isn't that type of a hearing. I'm trying to get information that we can use in Washington, but I would be glad to try to recognize a couple people, if I could, and I don't know how I can do it fairly other than to try to go around and discuss around the room.

I'll try to call on a couple people. If you would, just give your name and try and get it so the reporter can hear that.

MEMBER OF AUDIENCE. Why not reduce the oil depletion allowances? What about taxing those high income executives that are overpaid and undertaxed? And why not the corporation takeovers, tax that?

Senator HARKIN. In case you didn't hear that back there, he said why not do away with the oil depletion allowance, tax those high income officials—I guess you mean like Mr. Milken who made $550 million last year—and taxing corporate takeovers.

MEMBER OF AUDIENCE. Senator Harkin, I'm retired from the post office. I worked 1942 to about 1974. I've worked a long time. From the day I graduated from high school, June 1933, I've contributed a lot. Statistics say only 7 percent of the people need this catastrophic, and it is a catastrophy. We can sweeten the pot if we eliminate foreign aid and military aid to foreign countries. We've gone poor and bankrupt for 43 years. If it wasn't for the pension, let alone Social Security and military and private pensions, we'd have had a depression 10 years ago that would have made Herbert Hoover's look like prosperity. That's all. And one more thing I didn't mention, eliminate the star wars. Hell, Russia can have the Moon. Eliminate the space program. You haven't met one individual who wants to live on the Moon. I'll live at Glendale Cemetery. I'm 74 years old. How many years have I got left? Five, ten? I've helped my children now, but all over Iowa thousands of wealthy people and farmers—don't forget them—gave their wealth to their children and jumped on Medicaid.

Senator HARKIN. For 74 you sound pretty healthy to me. Back up in the back.

MEMBER OF AUDIENCE. Well, my main comment is that I'd like to see the surtax done away with and tax some other—as far as I'm concerned, I don't make $90,000, it's not going to bother me very

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a teenager, my father was on Social Security and in very bad health. By the time I got through college, he was then in his upper' seventies, and here we were—three boys. We were in the military—two of us were in the military, the other one had just graduated—and I had a handicapped brother. And we lived in a small town in rural Iowa, and my father was left by himself; my mother died when I was 10 years old. My father was left by himself, and at that time there wasn't Medicare, there wasn't anything like, Meals on Wheels, there wasn't anything like that for him. And every year, just as sure as winter would come, he would get sick. Because he was a proud man, he didn't want charity. He got sicker and sicker until finally they had to take him to the hospital. The bills would mount up, he couldn't wait to get out because he didn't want to burden his kids who still had college bills to pay for. And I can remember well the day that Medicare came in; I was still in the military at the time—and what it did to my father in terms of increasing his own livelihood and his well-being and what Medicare meant to him at that time.

I often think that had we had things like long-term health care, Meals on Wheels, that not only would he have lived longer, but his last years would have been a heck of a lot better than they were. And I often think about those days when I think about things like the catastrophic health care bill, and I think about things like long-term health care. And I think that, you know, those of us who are younger and who work earning incomes—in the old days, in my father's time and I'm sure in your parents' time, the young took care of their parents. My father took care of his mother until the day she died in his home. But yet because of the way we've evolved now we don't do that in our society any longer. Young people don't have the wherewithal any longer. They don't live as we did on farms and small towns and take care of people as we used to. It's sad to see that go, but it's happened, and we can't turn the clock back.

So what I'm saying is if you look back in the old days when a lot of the young people took care of their parents, they spent a lot of time and money taking care of their parents. They don't do that any longer, so I think it's incumbent upon all of us who are younger to once again admit that we are obliged to ensure that elderly do not go on welfare, that they are not thrown out in our streets, regardless of whether they're our parents or someone else's parents. I believe it's an obligation on all of us to ensure that that doesn't happen. And even though my parents are gone, I believe I have an obligation to all of the other parents of this country, who are 65 and older, to see that they are well taken care of, that they don't have to go out on the streets, and that they don't have to have their assets depleted down and go to the poorhouse just to take care of their health care needs.

So I just wanted to tell you that that's where I'm coming from. And as long as I'm in Washington, I'm going to fight to make sure the needs for our elderly, including health care and all other needs, are taken care of by not just the elderly, but by all of us.

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CONCLUSION OF HEARING

This will conclude the hearing. The subcommittee will stand in recess.

[Whereupon, at 11:50 a.m., Wednesday, April 17, the hearing was concluded, and the subcommittee was recessed, to reconvene at the call of the Chair.]

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